June 19, 2007

TRANSCRIPT

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MONTGOMERY COUNTY COUNCIL

Councilmember Marilyn Praisner, President
Councilmember Michael Knapp, Vice-President
Councilmember Phil Andrews
Councilmember Roger Berliner
Councilmember Marc Elrich
Councilmember Valerie Ervin
Councilmember Nancy Floreen
Councilmember George Leventhal
Councilmember Duchy Trachtenberg

June 19, 2007
Council President Praisner,
Good morning, ladies and gentlemen. I apologize for the voice; but welcome to Tuesday, June 19, 2007, at the Montgomery County Council. I would ask folks to stand for a moment of silence; and in the process of doing so, I would ask you to remember three individuals. On June 12th, the Montgomery County Government family lost Stephen Peters, a mechanic with Fleet Management, who was killed in a tragic incident at work. On June 11th, Detective Brent LaMere, a member of the Maryland-National Capital Park and Planning Commission Police Force died at work. And also, very recently, a Howard County police officer on traffic enforcement was injured and succumbed to those injuries. I apologize, but I couldn't find his name this morning; but I'm sure we can remember him as well. So please join me in a moment of silence and in recognition and memory of these three fine men who have served their communities and whom we remember. (Moment of Silence) Thank you. Our condolences go to the Howard County Government family. I believe there are no announcements for agenda and calendar changes, and there are also no petitions. So we will move, Madame Clerk, to Minutes.

Council Clerk,
Yes. We have the Minutes of May 7th, 9th, 10th, 15th, 16th, 17th, 22nd, and 24th, 2007.

Councilmember Leventhal,
Move approval, Madame President.

Council President Praisner,
Motion to approve is made by Councilmember Leventhal. Is there a second?

Councilmember Ervin,
Second.

Council President Praisner,
Second, Councilmember Ervin. All in favor? (Show of hands) Unanimous among those present. Thank you. We will now move to the Consent Calendar; and at the request of the Chair of the Public Safety Committee, we are pulling the item related to -- where is it? What item number is it? "T" -- we will pull item T and have a separate vote on that. On the whole consent calendar absent “T”-, is there a motion?

Council Vice President Knapp,
Motion for approval, Madame President.

Council President Praisner
Motion by Vice President Knapp; second by Councilmember Trachtenbeg. I see no lights on those items as well. Phil? Go ahead.

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Councilmember Andrews,

I just want to mention that item "B" includes a position description for the position as Director of the Criminal Justice Coordinating Commission. Our former colleague, Mike Subin, is here today and is serving as the director. I want to welcome him back and have seen him a lot already at our Public Safety meetings and look forward to continuing to work with him.

Council President Praisner,

I was going to wait until we confirmed the position before I acknowledged him. (Laughter) Okay. As Councilmember Andrews mentioned, item "B" on the Consent Calendar are the position descriptions/executive regulations for several positions which the Council previously approved as non-merit positions. I want to make one comment about that. The Management and Fiscal Policy Committee discussion yesterday included the conversation about the fact that the Office of Human Resources might spend a little time looking at the way we draft and format position descriptions. They are extremely redundant and wordy, and could benefit from common, current kind of thinking on these issues. So the Consent Calendar is before us with Item T removed. All in favor of the Consent Calendar? (Show of hands) Unanimous among those present. Councilmember Floreen has joined us. We will now move to item number "T"; and I'll turn the mic over to the Chair of the Public Safety Committee, Councilmember Andrews.

Councilmember Andrews,

Thank you, Madame President. It's a real pleasure to note the nomination – the appointment of Betsy Davis -- please come forward, Madame Davis -- to the Assistant Chief for the Department, one of three assistant chiefs in our police department. Commander Davis has served in many capacities extremely well in almost all of the districts in the County: as Commander of Silver Spring, Commander of Bethesda, lieutenant in various places. She also has served at Rockville, and at the Sixth District Station, the district in Montgomery Village, and spent a lot of time in the others also. She is well versed in all the different aspects of department policy and procedure, has a great record of working with the community, and is a real credit to the police department. And I want to note that there's a proud dad in the audience as well, Mr. Bob Davis who has served more hours as a volunteer than any other person in the history of the Montgomery County Police Department. He has over 40,000 hours now as a volunteer in the Silver Spring District Station – a remarkable contribution to public safety. And we appreciate that his daughter, Betsy, is now assuming one of the leadership positions in the department where she will oversee field services. So it's with real pleasure and a sense of gratitude to that family for their service, and I want to recognize Chief Manger's good judgment in appointing Betsy Davis to this position. So the Public Safety Committee unanimously recommends confirmation of this appointment.

Council President Praisner,

So the Public Safety Committee's recommendation is before us. Councilmember Leventhal.

Councilmember Leventhal
Thank you. I wanted to congratulate "Commander" Davis momentarily – it's just about to be Assistant Chief Davis. And I want to say this about Betsy Davis: She answers my e-mails. And when senior people in the Executive Branch do that, they get thanked and congratulated publicly by me. (Laughter) So there's every incentive to be responsive to Councilmember Leventhal's Office. She's been just absolutely super. Every time I've had a constituent issue, she is very promptly and thoroughly responsive; and I'm very grateful for that. And I strongly encourage her to continue in her new position because I do tend to send a lot of e-mails. So I'm very grateful for her responsiveness and thoroughness, and we are going to miss her in the Silver Spring District where I happen to reside. Obviously, I represent the whole County; but she's going to be hard to replace. She's been an outstanding commander for the Silver Spring District.

Councilmember Andrews
Madame President, I would just add that Assistant Chief Drew Tracy and Assistant Chief Dee Walker are here in the audience for this occasion.

Council President Praisner,
And they answer e-mails too, I'm sure. (Laughter) Councilmember Floreen.

Councilmember Floreen,
All right, thank you. Two things: One, I wanted to second the comments about Commander Davis. She's been a tremendous public servant to all of Montgomery County in the various positions in which she's served . And I would ask that my name be added in the previous votes on the Minutes, please.

Council President Praisner,
Without objection, thank you. And the Consent Calendar, sure. Councilmember Elrich.

Councilmember Elrich,
I'd also like to congratulate you on your promotion. I know that a lot of the civic people in Silver Spring have mixed emotions. You came highly recommended. People had nothing but the highest regard for the work you've done, and so they're going to miss you. At the same time, they feel like this is a real strengthening move for the Police Department. And so it's going to be good for the Department as a whole. So I congratulate you, and I look forward to working with you; and I'm sure you'll be as responsive in the future as you've been in the past, and that's a good thing. And I'd also like the Chair to do similarly, as with Nancy, to add my vote "Yes" on the other items.

Council President Praisner,
Certainly, duly noted. I'd like to add my personal comments as well. As Commander of the Silver Spring District, Betsy Davis has been responsive to folks in the areas of my district where that responsibility lies -- including attending numerous meetings. And she has an open, frank, "I can learn from you" approach when dealing with the community; and "we can work together." I think that kind of attitude is actually what we're talking about when we're talking about community policing -- that everyone in the community

owns the problem. And also it can contribute to the solutions that we're talking about. And your open and honest and frank and collaborative attitude working with the community has been very much appreciated, and I'm sure you'll take that to the next level. I congratulate Tom Manger for the selection, and I think that you will complement the other two folks in the room as well in bringing us a very strong police force. So I thank the Public Safety Committee for bringing this recommendation before us. The appointment is before us. All in favor of the appointment? (Show of hands) That is unanimous among those present. Would you like to say anything?

Betsy Davis,
Just remember I still live in Silver Spring. I may show a little favoritism, you know, at times; but I'm very honored that Chief Manger recommended my nomination. And I look forward to my continued relationship with the group here. I've met many of you over the years, worked with you, have new members/new friends now; and will continue to support the County government and the department 200 percent. I can't match the 42 free hours back here in the back; but, you know, maybe we can find a paycheck for him occasionally. But I appreciate the vote, and thank you very much.

Council President Praisner,
Well, it clearly shows the roots from which you come; and it's obviously reflected that you learned your lessons at home very well. And you should be very proud of your dad, as well as your dad very proud of you. Congratulations. (Applause) Thank you all very much. We are now going to move to convene as the Board of Health of Montgomery County. We've asked representatives from the Maryland Health Care Commission and the Health Services Cost Review Commission to join us this morning to broaden the County Council's/Board of Health's understanding of the health care regulatory structure within the state of Maryland; to help us to understand the Certificate of Need process; and also the Rate process as we discuss those issues from a state perspective and understand that. So I'm going to -- Whitney? There you are. This is Whitney's first foray publicly as our staff Senior Legislative Analyst who is going to be handling Health and Human Service issues. Whitney Obrig -- and I thank you for your presence. I would ask folks who are here to brief us to join us at the table, and Councilmember Berliner wanted to speak.

Councilmember Berliner,
Only very briefly, Madame President, to be recorded in the affirmative with respect to the Consent Calendar.

Council President Praisner,
And the appointment?

Councilmember Berliner
And the appointment, absolutely.

Council President Praisner,

Madame Clerk, duly note, please. Okay. Thank you. Join us at the table, please. We are televising this; so I would ask you all just to press the mic in front of you and introduce yourself for the benefit of the television audience. Thank you.
Pam Barclay,
Thank you very much, Madame Chair, Councilmembers. I am Pam Barclay. I am Director of the Center for Hospital Services for the Maryland Health Care Commission. I think what we would like to do, if I can perhaps go to the next slide –

Council President Praisner,
Why don't all of you, while they're getting the slides set up, introduce yourselves. It will help the television process.

Paul Parker,
I'm Paul Parker, Director of the Certificate of Need Program, with the Maryland Health Care Commission.

Council President Praisner,
Thank you.

Robert Murray,
Good morning, Madame Chair and members of the Council. My name is Robert Murray. I'm the Executive Director of the Health Services Cost Review Commission.

Council President Praisner,
Welcome, Mr. Murray. Thank you very much for being here. Thank you all very much for being here.

Pam Barclay,
Thank you very much for inviting us. What I'd like to do is give you a little bit of background on the Maryland Health Care Commission. We'd then like to give you some background on the Certificate of Need Program in Maryland and talk about the scope of Maryland's Certificate of Need Program; go through the review process so you understand kind of the steps and timing involved in that process; and talk about the ways that participation in the review process is facilitated.

Council President Praisner,
That's perfect.

Pam Barclay,
Then we'd like to spend a little bit of time talking about recent trends in health facilities use and investment, and talk also a bit about health facilities in Montgomery County. Just to give you a little bit of background on the Maryland Health Care Commission, the Commission was established in 1999 by the Maryland General Assembly. The Commission actually merged two existing Commissions, the Maryland Health Resources Planning Commission and the Health Care Access and Cost Commission. We are organized in five centers. The Center for Hospital Services, which is where the

main part of the Certificate of Need Program is located; and we will be doing the briefing today for you. But I also wanted you to be aware of some other parts of the Commission. We have a center for long-term care and community-based services; we have a center for financing and health policy; a center for information services and analysis; and lastly, a center for health information technology. The Commission itself is governed by 15 commissioners who are appointed by the governor with the advice and consent of the senate. And I've listed our current commissioners on this slide, so you can see who they are. What I'd like to do now is introduce Paul Parker. He will go through the Certificate of Need Program process and steps. He will also give you some background on the packet of materials that we've put together for you this morning. Thank you very much.

Council President Praisner,
I want to wait until they're done with the presentation. I've been asked how we're going to handle questions.

Pam Barclay,
Oh, okay.

Council President Praisner,
It would be better if we go through the presentation; and then we know how much time we have left, and we can manage the questions that way. Okay? Thank you. So Councilmembers can write down their questions as they're going along – well or remember them. However you like.

Council Vice President Knapp,
Whatever works for you.

Council President Praisner,
Whatever works for you.

Councilmember Trachtenberg,
You have coffee, don't you?

Council President Praisner,
I apologize for questioning the memory capacity of my colleagues. (Laughing) Go ahead.

Paul Parker,
Good morning. The Certificate of Need (CON) Program regulates the supply and the distribution of certain types of health care facilities. So in other words, to establish certain types of health care facilities in Maryland or to modify existing health care facilities in certain ways, one must obtain a Certificate of Need from the Maryland Health Care Commission. This is a program that's been around for quite a while -- since the early 70s. For a while, Certificate of Need programs in every state were mandated by the federal government, from about the mid 1970s through the mid 1980s; and there

was a great deal of funding to support those efforts. That's been gone now for 20 years or so; but states have maintained, for the most part, Certificate of Need programs. They're currently operating in 36 states and the District of Columbia, although over time they've evolved and changed; and the scope of CON regulation varies considerably from state to state. CON was originally created, I think, on the basis of some key assumptions about the way the health care market operates. Conventional market forces are considered to be weak or flawed, so that we don't see a kind of self-regulating supply -- balance between demand and supply in health care service delivery. And also with particular types of specialized services, there's a clear relationship that's been established between quality of care and improved outcomes and the volume of service that's delivered, which is related to the level of proficiency that can be achieved at higher volumes. And then lastly, unregulated market entry into the health care field is considered to possibly result in inequitable availability and accessibility for some disadvantaged populations. Of course, that's related to the pluralistic financing system in many ways that we have for health care. Now, to my first mistake of the day. There is a scope slide which is missing here, so forget that one for a second. In your packages, there was one loose slide; and it says, “The Scope of CON Regulation.” What we've listed here are the five categories of project which require a Certificate of Need. And to some extent, this is a little simplified. If we went into every nuance of the scope of the CON Program, we could take a lot of time this morning; and I don't think that's really necessary. But basically, establishing a new health care facility requires a CON. And the definition of “health care facility” includes hospitals, nursing homes, ambulatory surgical facilities, residential treatment centers, home health agencies, and hospice programs. And one wrinkle of the Maryland program, which you’ll note there, is that an ambulatory surgical facility is only a regulated ambulatory surgical facility if it has two or more operating rooms. So we have lots of one-operating-room facilities in Maryland -- more than anywhere else in the United States. We have the highest per capita number of ambulatory surgery centers in the United States. Moving an existing health care facility to another site requires a CON. Changing the bed capacity of a health care facility; changing the type or scope of any health care service offered by a health care facility; and specifically, what the law regulates under this area are establishing new medical services. And what we're talking about here are four categories of acute inpatient service: medical/surgical services, obstetrics, pediatrics, and acute psychiatric services. Comprehensive rehabilitation, chronic care, comprehensive care – which is nursing home care -- extended care, intermediate care, residential treatment, and anything else that's specified in the State Health Plan which is a form of regulation under the purview of the Maryland Health Care Commission. Four specific clinical services offered in the hospital setting: open heart surgery, organ transplant, burn treatment, and neonatal intensive care services are regulated specifically if they’re introduced as new services. Building or expanding ambulatory surgical capacity at a hospital requires a CON. Closing an existing facility requires a CON. Then the last category is even if you don't fit under the first four, if you're spending above a certain capital threshold, that requires a Certificate of Need. For hospitals that’s currently $10.1 million; for other types of health care facilities, $5,050,000. And that’s indexed for inflation, so that goes up over time. One thing I want to mention related to this last one – and this is kind of unique to Maryland because we

do have hospital rate regulation -- hospitals who don't come under any of the first four definitions but are making a capital expenditure above the threshold can actually avoid having to get a CON for that large expenditure if they do what we call “taking the pledge,” which means that they get a determination of coverage from the Commission, and it's also looked at by the Cost Review Commission. It says, "We don't need a rate adjustment of any significant size in order to finance this capital expenditure." So that's something that doesn't exist in most states. Most states – or a lot of states -- have a capital spending threshold that they use in Certificate of Need, but they don't have rate regulation; and you pretty much have to get a CON if you spend above that amount. In Maryland, you can avoid that; and a lot of hospitals have over time. Okay. Now, we're back on track. This is a diagrammatic representation of the Certificate of Need review process. It starts with a letter of intent, and we have a conference with applicants to talk about any assistance they need with developing an application. Applications are submitted sixty days later. Those undergo a completeness review in which we ask questions or seek any clarification that we need on the material in the application. After we get that response back and the application is complete, the application is docketed -- which is the start of the formal review and actually starts the clock. And then there's a 30-day public comment period after docketing; and that's an important period for interested parties or participating entities -- people who want to have some sort of a formal role in the review of an application. They have to communicate to the Commission their interest in being an interested party or participating within those 30 days. So then you have two tracks. If we don’t have any sort of contested application, we're on that first track. Project status conferences occur if after reviewing the application, staff -- or in the case of a reviewer on the other side -- wants to see a modification in the application because it's not consistent with our State Health Plan or there’s a problem with the review criteria that the Commission uses, but feels that the application can be approved with some changes. A project status conference serves that purpose. And an applicant can choose to modify along the lines proposed, or go forward in the latter case, probably with a negative recommendation. So we have either a staff report and recommendation, or in the case of a contested application where we have an interested party, we would actually have one of our Commissioners appointed to review the application and act as a reviewer. And then he or she works with staff to review the application. And so in that case, it's actually a reviewer who’s making a recommendation to the full Commission; and then we have a Commission decision. For uncontested cases, it's 90 days after docketing -- is what we shoot for in terms of getting this on the Commission agenda for final decision. Contested case is 120 days. About 80% of our CON applications are uncontested. And we took a look at how well we're doing in the last five years. On average, our uncontested cases were actually taking about 125 days; so we are working on trying to get that back down within our 90-day target. The median was about 103 days. Next. These are the six -- or a summary of the six required considerations that the Commission must make in reviewing any CON application. They're looking at consistency with the applicable State Plan health care standards. Again, that is a set of regulations that consists of standards for particular types of projects that are developed by the Commission. They look at the need for the project. They look at the cost-effectiveness of the project. So in other words, after we’ve identified what the need is or what the objectives of the project are, the applicant is

expected to show that they've looked at alternative ways of implementing or achieving these objectives, and that they've chosen the most cost-effective approach; the financial viability of the project, which includes financial feasibility; compliance of the applicant with terms and conditions of previous CONs that have been issued to the applicant; and the impact of the project on costs, charges, and other providers. I want to spend a few minutes now with a little more detail on participating in the review process -- participation by folks other than the applicant. There's two categories of participants. The first is interested parties. As I mentioned previously, you have to seek interested party status within 30 days after an application is complete and docketed for review. A reviewer will be appointed – one of our commissioners – to look at that interested party filing and make a decision as to whether or not you qualify as an interested party. We have some people who automatically qualify, or I think it's fair to say they automatically qualify: the applicant Commission staff and local health departments and jurisdictions or applicable planning regions in which a project is located; and the other two categories of persons who can qualify as an interested party: third-party payers who can demonstrate substantial negative impact on overall cost to the health care system if the project is approved or persons demonstrating adverse impact or adverse effect by approval of a project in an issue area over which the Commission has jurisdiction. Next slide. Again, you have 30 days after docketing to file. The request has to include information that the interested party wishes the Commission to consider in its review. And if opposing the application, those comments need to identify the specific State Health Plan standards or review criteria that the interested party does not feel have been met by the applicant, and the reasons that the project doesn't meet them. And we're looking for documentation or sworn affidavits supporting factual assertions in this area. And then what does an interested party get as far as their role in the review process? They receive all correspondence between the Commission and the applicant. They're provided an opportunity to attend all meetings or conferences with the applicant. They can file comments on any changes made in the course of the review by the applicant. They can request an opportunity to make oral argument to the reviewer before a proposed decision is issued. Again, if we have an interested party, we're going to have a Commission reviewer involved in the review. They can file exceptions to a proposed decision. They're allowed to make brief oral argument to the Commission prior to final action on an application at the Commission meeting. And after the Commission takes final action, an interested party has standing to appeal a Commission decision for judicial review. Now, the lesser type of formal participation -- next -- is the participating entity. Participating entities, again, have to file for this status within 30 days of docketing. They have to be officially recognized by the Executive Director of the Commission as qualifying. And this status is limited to third-party payors; a jurisdiction in the health planning region where the project is located that is used for purposes of determining need under the State Health Plan -- that region can vary depending on the particular type of service or project we're looking at; and lastly, a municipality where the proposed project will be located. Again, 30 days to file. The request needs to include information that they wish the Commission to consider in its review, and the comments have to identify the State Health Plan standards or review criteria that have not met. Next. Participating entities, like interested parties, get all the correspondence that occurs in the review process; and they're provided an opportunity to attend meetings

and conferences. They can file comments on proposed changes. They can request an opportunity to address the Commission, but that's -- unlike interested parties, that's really at the discretion of the Chair, whether or not he or she wishes to allow that. And they do not have any standing for appeal of a decision -- kind of one of the big differences between a participating entity and an interested party. Some recent trends in health facilities use. On the hospital side, a long-term decline in hospital patients census came to an end, broadly speaking, in Maryland and also throughout the country in the late 1990s. So what we've seen, for the first time in a long time in the last few years, is we actually see the inpatient census at hospitals growing -- from 2000 to 2007, over a thousand patients statewide -- somewhat slower pace of increase in census in Montgomery County. Outpatient services, both in hospitals and in freestanding settings, has experienced tremendous growth; and this trend continues. Maryland actually has a CON program that does not regulate a lot of the services outside of the hospital and freestanding centers that are regulated in many other states -- for example, diagnostic imaging. That hasn't been regulated in freestanding settings -- or specifically, in hospitals even --since the late 1980s. We do still regulate ambulatory surgery centers with two or more operating rooms, but that's about it. To show you just kind of an example of the growth that's been experienced though in ambulatory surgery from '97 to 2005, the case volume of outpatient surgery in Montgomery County increased 231% -- a little bit higher, I think, than the statewide average; but there's been a tremendous increase statewide as well. We have a long-term decline in nursing home use rates, and that is continuing. We've had about a 5% decline in the total number of nursing home beds in Maryland since 2001. That was a decline that actually began in the 1990s. The state pretty much topped out in terms of the number of nursing home beds around the mid 1990s, and it's been gradually declining since then. So we're seeing a long-term trend of declining admissions to nursing homes. Unfortunately, this is a terrible slide to try to read; I think you can read it better on the paper. And it's actually an older slide that we stuck in here; I wasn't able to find an updated one. But this does show you that we've had a tremendous increase in recent years in CON activity -- CON applications filed. And actually in 2006, you see a similar continuation of a much higher number of applications than we saw prior to, let's say, 2002. We have had 93 CON applications reviewed in the last five years. Approximately 82% of those have been approved, either as proposed or with conditions; 6% have been denied. About 12% were either withdrawn during the review process or relinquished after receiving a CON or actually revoked because the applicants failed to meet the performance requirements. If you get a CON, you have to actually implement the project within a certain period of time, or else the CON is voided. We do a lot of reviewing of various types of projects and activities outside of formal CON review too – about 160 determinations of coverage in the last year. This involves acquisitions. We do require notification and certain information whenever health care facilities are acquired -- the determinations of coverage to establish the single operating room AFCs, other types of non-reviewable changes to facilities that require at least notification and review by the Commission. And this slide contains my second mistake of the day. This is just to give you an idea of what we have here in Montgomery County in terms of the inventory of regulated facilities – the types of facilities that fall under CON regulation: 5 acute care general hospitals, which you're probably familiar with; 33 licensed nursing homes, and 2 which are

temporarily de-licensed. Those beds in those two facilities may eventually come back online, and we won't get into that process; but there is a short-term process where you can come offline with these types of beds, and they can come back under new owners or in a different configuration. We have 1 freestanding acute psychiatric hospital; 2 residential treatment centers; 1 freestanding comprehensive rehabilitation hospital; 69 freestanding outpatient surgical facilities. That's the total; and, again, not all of those fall under CON regulation. Many of them were created through a determination of coverage and have only a single operating room. These last two -- there are actually ten home health agencies that are licensed with their base in Montgomery County, but this is not the total that serve Montgomery County. There's actually 17 who are authorized to serve Montgomery County residents. And I pulled these off the licensure directory; and, unfortunately, the person who gave them didn't recognize there was a difference there. Four hospice programs – again, four that are actually licensed with an address in Montgomery County; but there's actually eleven different hospice programs that are authorized to serve Montgomery County. In terms of hospital activity -- as probably most of you are aware -- in the last few years, we have had three of the five Montgomery County hospitals undertake fairly major projects. Holy Cross Hospital in 2001 received a CON for a major expansion and renovation – close to $90 million. Shady Grove in 2005 had a similarly-sized expansion and renovation proposal, which included the addition of beds. And we're currently reviewing -- and we'll probably act this month -- on a proposal by Montgomery General Hospital. A little more modest application that's going to come in, I think, under $40 million; but it will replace the emergency room in Montgomery General and add quite a bit of space for outpatient services and some shelf space. And then as you know, we're anticipating in the next couple of years probably looking at the other two hospitals in Montgomery County coming in for major CON reviews: replacement and relocation of the Washington Adventist Hospital, and Suburban Hospital is also looking at a major expansion and renovation project down the road. So that concludes my briefing.

Council President Praisner,
Thank you. Okay. Is there anything else that you all would like to say before we get to councilmember questions – anything from a procedural standpoint? That's it? Okay. Councilmember Leventhal.

Councilmember Leventhal,
Madame President, thank you very much for scheduling this extremely informative and timely briefing. It's really great to have the chance to learn a lot about something I really need to know and didn't know much about before. That's just very, very helpful and timely. It sounds to me as though the issues on which either a local government or community members can weigh in with the Commission are very strictly limited. And if I'm understanding the slides correctly, let's just start with what a local government – that is, the County Government – the County Health Department, which is an automatic interested party -- may weigh in on. The interested party may only, if I'm correct, submit information regarding the State Health Plan standards or review criteria that have not been met. And those are identified in your earlier slide, and they mostly relate to economic issues having to do with the bottom line of the health care provider in

question and other health care providers. So if -- tell me if anything I'm saying is wrong. On this slide, "Required Considerations and CON Review" -- need for the project, cost-effectiveness of the project, financial viability, compliance with terms and conditions of previous CONs, and impact on cost charges and other providers -- what about access to health? What about the public health considerations? Is that a factor? Will people have more or less ability to get access to health care? Is that one of the considerations that the Commission looks at?

Paul Parker,
Well, yeah. I mean, that first one's a big one. It's the State Health Plan.

Councilmember Leventhal,
The State Health -- consistency with applicable State Health Plan standards. So broadly, that would address whether people are going to get more or less health care.

Paul Parker,
Many of the State Health Plan chapters for particular categories of project or facility actually do speak to standards for access, availability, quality of care.

Councilmember Leventhal,
Okay.

Paul Parker,
So, yeah. These are the six criteria; and they are broadly stated. They're summarized here, but they are broadly stated in the regulations.

Councilmember Leventhal,
Okay.

Paul Parker,
But that first one actually involves a lot of very specific standards that deal with very different types of criteria.

Councilmember Leventhal,
Okay. Are those contained in the packet – the actual State Health Plan standards? Do we have those?

Paul Parker,
No. And the full State Health Plan is a very large body of regulations.

Councilmember Leventhal,
Okay.

Paul Parker,

But we can certainly provide you with those or particular categories or particular chapters of the State Health Plan that deal with specific types of projects that you're interested in.

Councilmember Leventhal,
Okay, thank you. I would appreciate that. Now, my next question is: If you're not an interested party -- those defined as the applicant, the Commission staff, or the local health department --and you're not a participating entity, which is a third-party payor – again, another government jurisdiction or municipality -- you can't really weigh in – that is, if you're an advocacy group or neighborhood association or a member of the public. There really isn't an opportunity for those – unofficially, I would say -- interested people to communicate with the Commission; is that correct?

Paul Parker,
Well, no; I wouldn't say that.

Councilmember Leventhal,
Okay.

Paul Parker,
They don't have a formal role in the review process the way an interested party or participating entity does, but anyone who wants to weigh in on a project can write to the Commission. And they have access to all of the information that's filed by an applicant. That's public information –

Councilmember Leventhal,
Okay.

Paul Parker,
-- and we can make that available to anyone who wants it. And we do actually look at all of the input we get on applications.

Councilmember Leventhal,
Okay.

Paul Parker,
So we do get certainly letters and sometimes fairly detailed types of arguments that are filed by people who don't have a formal role. They're not interested parties, but they are concerned citizens. We get lots of letter from people who are just supporting a project –

Councilmember Leventhal,
Sure.

Paul Parker,
-- and really want to let us know that.

Councilmember Leventhal,
And those are duly considered?

Paul Parker,
Yes.

Councilmember Leventhal,
Even if they can't be categorized in one of these boxes: compliance with State Health Plan, effect on – you know, these criteria. Even if they -- an ordinary member of the public, for example, who wants to weigh in should send a letter to the Commission; and it isn't required that the person have detailed knowledge of the criteria by which the Commission will make a decision and then document how his or her input fits with that. That's not necessary.

Paul Parker,
Well, I would say again, the Commission has a specific role in terms of what they are expected to look at when they're looking at a project; and that's really outlined in those criteria. If they receive input from someone whose complaint -- or the information that they're providing about a project is really something that's pretty far afield from what the Commission has been asked to look at in the law, it's difficult for the Commission to obviously deal with an issue like that. I mean, if someone –

Councilmember Leventhal,
What's an example of something you would consider far afield?

Paul Parker,
Well, for example, the things that are actually governed by local government in terms of site, plan approval, and zoning –

Councilmember Leventhal,
Mm-hmm. Not relevant to the health care –

Paul Parker,
We certainly get that, but those are – we really don't have jurisdictions over those areas. They're important kind of secondary issues for the Commission because those go to the ability of an applicant to actually do the project that they've asked the Commission to approve.

Councilmember Leventhal,
Sure.

Paul Parker,
So we are interested in looking at those issues and how the applicant is dealing with them. But in terms of someone who's appealing to the Commission to, you know, stop

this site plan from being approved or change the zoning or do something about the zoning variance that's being requested, that's a difficult issue for the Commission to address in any meaningful way.

Councilmember Leventhal,
Yeah. And I know the answer to this question, but it's important to get it on the record for those who are paying attention. Approval by the Health Care Commission does not preempt the also-needed approvals by those other entities that you're talking about. So for example, a hospital located in a residential zone in Montgomery County must have a special exception granted by the Board of Appeals with input from the Planning Board. The fact that something is approved by the Health Care Commission does not preempt the legal requirement that they also go ahead and get the local approval from the Board of Appeals with input from the Planning Board. Similarly, if a zoning change is required for a facility to function, that must come before the County Council; and approval by the Maryland Health Care Commission does not preempt the requirement that the County Council adopt that zoning change.

Paul Parker,
That's correct.

Councilmember Leventhal,
Okay. Last question for me; I know many other members have questions.

Council President Praisner,
We do have another presentation too on the Rate issues.

Councilmember Leventhal,
I see. Okay. Okay. Could you walk us through the history on the Germantown outpatient emergency facility? Just so we understand sort of how -- there was a workaround there, and I don't understand the details of it; and maybe you could just walk us through that. That is, Adventist Health Care System wanted to open a facility that many of us thought was needed from the standpoint of access to care. That for people in the In the Upcounty, it was quite a distance south to Shady Grove or north to Frederick; and yet the Health Care Commission on its criteria said, "We don't think it is needed." And I guess the basis was that it would have an adverse impact on the health care providers at Shady Grove and Frederick; and then there was some legislative workaround, which I don't understand the details of. Could we -- is it possible to walk us through how that occurred?

Pam Barclay,
Sure. I'd be glad to try and do that. The Germantown Emergency Center -- that proposal actually started at the Commission as a proposal to develop a five-bed hospital in Germantown. And the Commission had concerns about developing that small a hospital in Germantown, and it was a financial feasibility issue because of the small number of beds. We did turn that proposal down. The proposal then developed into a piece of

legislation in the General Assembly, as you point out; and the Commission worked with representatives from Shady Grove, as well as the General Assembly, to craft what we think was a really good solution to some of the access issues in Germantown. And we reflected this in our decision to turn down the five-bed hospital. We said, “We think there's a need for a health care facility in Germantown.” We had concerns about a small number of beds. So what developed was a pilot program to establish a 24/7 emergency center that accepts appropriate patients via ambulance, and we are now collecting data from that facility as a pilot. We are due to report to the General Assembly in December of this year on whether that's a model that we ought to develop in other parts of the state. So, and I think -- that's -- the Commission supported the legislation to set up that pilot; and we are looking at it right now in terms of trying to see if that's a way to provide access to services and to look at the merits of that model of care.

Councilmember Leventhal,
Thank you very much.

Pam Barclay,
Uh-huh.

Council President Praisner,
Councilmember Berliner. I do want to apologize first and alert my colleagues. There is the second presentation that we will have on the rate-setting process. So to the extent folks have interrelated questions, which I have, you may want to hold them until after the second presentation. Councilmember Berliner.

Councilmember Berliner,
Thank you. Let me commend the two of you for an excellent presentation. We all endure lots of briefings. This was superb. Okay? Really very well done. Let me ask you to turn to the "Required Considerations" in your review and look at the “need for the project.” My question goes to whether or not you separately analyze, if you will, different facets of a proposed project. There are projects which include expanding hospital beds and hospital facilities. There are aspects of a project which can include a commercial office that would relate to the hospital. And there are aspects of a project that relate to parking. When you look at "need for the project," do you separately assess the need for each individual component of the project, or do you look at it as a totality?

Paul Parker,
I'd say “yes” and “yes.” We are looking at the totality of a project in terms of trying to kind of reach an overall set of findings and conclusions and recommendations. But in projects -- major hospital expansions and renovations -- you're right; they can contain a lot of different elements. They may be actually affecting a whole range of different clinical services. And the State Health Plan chapters that are applicable to a project like that may have more than one specific set of need standards that are applicable to a particular aspect of the project. So, for example, if the project is adding beds, we do have a bed-need methodology and a standard for looking at bed need that we would use in looking at that particular aspect of the project. We don't have a methodology for

determining how many parking spaces are needed; but we do have an overall standard, for example, in our hospital chapter of the State Health Plan, where hospitals are expected to basically carry the burden of proof with respect to need for the various elements of their projects. So in that case, where basically the hospital is coming in and saying, "This is why I need this 600-car parking garage to go along with this overall expansion of my campus," they're basically expected to demonstrate -- using their assumptions and their facts and their analyses -- why that is a needed component of the project. So typically with a big, complicated project, we have some specific need standards that apply to specific parts of the project. In other areas, it's basically the applicant who is trying to demonstrate to us and show us -- through the facts that they present and the soundness of their planning process and their assumptions and their analyses -- that these are also needed as well, even when we don't have specific standards in those areas.

Councilmember Berliner,
And when you do that, let's focus for purposes of this question, on a commercial building that would house physicians that would have some relationship with the hospitals that is not part of the hospital per se. Do you assess when you look at the "need for the project" – does need equate to profitability, or do you look -- I need to understand what "need" means in this context. I am assuming that someone would put forth a proposal that would make them additional dollars. That doesn't mean to me that it is "needed." So I would appreciate your conversation with respect to that and how you assess need.

Paul Parker,
We focus on the needs of the service area population; you know, that's the level that we're operating in. It's not a need for greater levels of revenue by the hospital or some business opportunity. Maryland is primarily, in the hospital sector, a nonprofit industry. We only have one for-profit hospital in the state. So obviously financial viability -- financial feasibility of capital projects is one of the required considerations. So we are very much interested in looking at the ability of the hospital to do a project feasibly. They have to have the resources. They have to have the debt capacity. They have to have the existing rate structure that's going to support, on an ongoing basis, the costs that they're going to have related to a project like that. But need is really focused on what is the service area population that your institution is serving if we're talking about an existing hospital. What are the particular needs of that population that come from demographics and socioeconomic characteristics? How are you meeting those needs now, and why is the project that you're putting forward here -- how can you show us that this is actually something that your population needs or is going to need in the future in terms of increased capacity or new services?

Councilmember Berliner,
Thank you. Appreciate those answers.

Council President Praisner,
Well, I was going to go to Councilmember Floreen; but I'll go to Vice President Knapp.

Council Vice President Knapp,
Thank you, Madame President. Thank you very much for the presentation. Just a couple of quick questions. Kind of building on the required considerations for the CON review, is this solely a reactive process on your part? Or are there any circumstances under which -- looking at the State Health Plan standards or requirements or needs for accessibility in certain communities -- that the Health Commission would actually say, "We recognize that because of extreme growth -- or whatever -- in a certain area that there is a need for additional health resources to be provided here." And if so, how would that occur?

Paul Parker,
I can give you a good example that's currently underway. We updated our State Health Plan with respect to home health care in the past year. For a number of years, we have not identified a need for additional home health care agencies in Maryland. But, again, in updating our plan earlier this year, we looked at how client volumes are growing in the various jurisdictions of the state and made some assumptions about what's kind of a reasonable capacity for home health agencies. And we identified three counties, one of which is Montgomery, where we're going to open it up for competitive review of additional home health agencies in three jurisdictions. So that's an example where in CON it is very proactive. We have a threshold where if there's no need, we're not accepting applications for new home health agencies. We now have a plan, and we've put a schedule out there that's going to allow those three counties to have competitive review cycles in the coming year. The Commission will look at all the applications that come in, and we'll approve at least some of those so people can enter those three jurisdictions as new providers. In other cases, I think it is more reactive.

Council Vice President Knapp,
So in a hospital situation where there has been some growth in the number of hospitals we've had in this region, but not significant – at least it appears not significant given the population growth that has occurred. But because the hospitals are so large, is that something that’s typically more reactive; or are you looking at – I mena, you point to the amount of growth that we're seeing in patient census data. Is there some threshold that you’ll cross and say, "Wait. We've turned this corner since 2000, and now we’ve gotten to some number that we really need to go back and look and make sure we’ve got the right number of hospital resources"?

Paul Parker,
Yeah. The Commission responded to kind of the shift that we saw in inpatient utilization a few years ago; and for the first time in many years, we put out a projection of net need for additional hospital beds for many of the jurisdictions in Maryland, including Montgomery County. And as long as we’re seeing this shift with greater discharge rates and a more slowly declining average length of stay, we’re going to continue to update those projections. We’ll have an update actually coming out later this year, which pushes us further into the future and will identify additional need for beds. We haven’t finalized that projection yet; but I can tell you right now that it’s going to be identifying

greater net deficits of hospital beds. And that does open up opportunities for hospitals then to come in and seek additional bed capacity.

Council Vice President Knapp,
Okay. Great. Thank you. In the participation in the review process, you have the automatic interested parties – of which, I guess, our local health department would be automatically identified as an interested party. As you said, you take input from everyone – be they letters that people send or from the interested parties specifically. One of the things I'm curious as to – as an interested party and the County responds, is that heavily weighted as the local health organization providing that input? Is it just one other piece of the puzzle that needs to be assessed? One of the situations we've had as we've tried to look at where the County should participate is, How significant is our participation in a process? If we really weigh in heavily and we feel we're heavily invested in something, is that given a lot of weight on the part of the State? Or is that one more piece that needs to be taken into consideration – but only one more piece?

Paul Parker,
Well, yeah. I think it's fair to say that a local health department is going to be considered to be an important commenter or interested party in any review. But I think the real weight that's given to the input that we get from an interested party is really kind of based on the quality of that input. I mean, it's the importance of the issues that you've identified and the case that you've put forward as to why is this is an important issue, or why is this some element of this project which we're unhappy with or we think needs to be modified or changed in some way. To the extent that you can really carry that argument well and show that yes, indeed, based on the criteria that the Commission is working with, this is really a relevant comment and is on target. That's what's going to carry the most weight.

Council Vice President Knapp,
Okay. Great. Thank you very much.

Council President Praisner,
Councilmember Floreen.

Councilmember Floreen,
Thank you. This is, indeed, a very interesting conversation given what we are contemplating occurring in the Montgomery County health care environment over the next year or so. Could you talk -- follow up on Mr. Knapp's question. Could you talk a little bit about what kind of commentary from a local health department or County is relevant – is useful to you? We'll have to check out the State Health Plan criteria, but what is it that a local health care program or county can provide that, say, another interested party could not? What is the kind of information that would be helpful to you all in making your decisions?

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Paul Parker,
Well, I think probably the first thing that would come to my mind is in that many cases, you actually see a partnership between the public health authorities in a jurisdiction and the hospitals. In other words, the hospitals are often participating in collaboration with the public health folks in running certain types of clinics that serve low-income women, for example, for prenatal care -- or children. So to the extent that some change in a hospital – for example, a change in site or some change in the way that hospital's configured might have an impact on that relationship or might change the availability or accessibility of those types of resources -- I could see a health department kind of raising some concern about what a hospital's doing in that area.

Councilmember Floreen,
Would you, on your own, be looking at things like the income health status in say even English language proficiency of a service area on your own? Or is that something that you would need the local health department to provide to you in evaluating the availability and accessibility criteria which you had on your slide and I guess is in the health plan?

Paul Parker
Yeah. Well, I think we try to look at it the characteristics of the service area population when we're evaluating a project and what is going to be the impact of that project on the way this hospital functions or this health care facility functions in serving its population. But I think a local agency may actually have a perspective that we might not get just from kind of looking at the big picture data that we might tend to look at at the State level. They might have some different perspective on particular sub regions of the jurisdiction or certain populations that they've served and kind of understand the cultural competencies that are required to effectively serve them – you know, what sort of access and transportation issues might be affecting particular populations. That would be better than what we would easily be able to tease out.

Councilmember Floreen
So that would be something uniquely within the range of a local health department in terms of providing you with information you might not have your fingertips on.

Paul Parker,
I think so.

Councilmember Floreen,
What about cross-jurisdictional issues? Would you look at service -- define a service area that includes the District of Columbia? How does that work? As you know, we've got neighbors.

Pam Barclay,
Well, I think for specialized services, we do . For open heart surgery, for example, the service area -- the metropolitan Washington service area includes Montgomery, Prince

George's, the District of Columbia, and the Tri-County Southern Maryland region. So that is the service area we use for planning.

Councilmember Floreen,
Sure.

Pam Barclay,
For organ transplant services, the service area even includes northern Virginia; and that's based on federally-designated organ procurement regions. So for certain services, we do include -- go across even state boundaries for planning purposes.

Councilmember Floreen,
But those are specialized areas where you would take that into account?

Pam Barclay,
Right.

Councilmember Floreen,
With respect to more mundane or less clearly categorizable services -- the classic emergency room treatment for the uninsured perhaps, or other more standard kinds of complaints -- would your inquiry extend beyond Maryland borders?

Paul Parker,
Well, yeah. I mean, when we're looking at any particular facility or service, we are looking at patient origin. So if we had a Maryland hospital with an emergency department that was being heavily affected by patients coming from the District of Columbia, when we looked at a project that was changing that emergency department -- expanding it in certain ways -- that's one of the things that would go into our analysis. In other words, we wouldn't just kind of focus strictly on Maryland population and how it uses the service. We would recognize that this is historically a migration that's occurred, and we would take that into account in looking at what is the likely path of growth in volume in this service.

Councilmember Floreen,
Just looking through your regulations, I saw you had some extensive definitions of service area based on current experience more or less. When a hospital relocates, do you -- how relevant is that -- the service area issue -- in terms of defining need and, I guess, accessibility? And to what extent do you look at the implications of an adjustment in service area for other hospitals?

Paul Parker,
We do use different definitions of service area for different services because obviously there are some services that require, for example, a larger population base really to justify a program. So when a facility is relocating, depending on what the mix of services are that it uses, different examinations of service area will come into play based on different services. But even though we are establishing certain definitions of service

area and certain standards for different services at those service area levels, we're also examining in any Certificate of Need – we're examining the actual service area – the actual patient origin. And we do have good patient origin information that can give us insights into the actual service area that's being served by a particular institution, no matter what boundaries it crosses.

Councilmember Floreen,
Well, I know. But if it changes or extends its service area to one degree, one would naturally assume that that would have implications for a variety of other service area definitions based on characteristics of the patient population and, you know, whatever – transportation, accessibility, and, of course, particular foci within the hospital program itself.

Paul Parker,
Right.

Councilmember Floreen,
So do you figure that out on your own, or do you need the other players to bring that to your attention?

Paul Parker,
A facility that's relocating is going to have to give us a detailed analysis of how it believes its service area population will change because of the relocation. And obviously, the last required consideration – impact on other providers – becomes a very important criteria whenever we're looking at a relocation. So we're going to be looking at what the applicant has provided in terms of its analysis of what changes are going to occur. We're going to use our experience in looking at other relocations that have occurred in the past. We're going to be looking at input that we get from other facilities who may be affected by this change. And in this case, we almost certainly will get their analyses as well of how they think the change will have an effect on them and how they think it will change service areas and patient migration patterns. So we're assessing it from a number of different levels and trying to reach some conclusions on what do we think is the most likely impact of a change in location? How is that going to change the service area population? Who's going to gain and who's going to lose access? How will this affect market share? How will it affect the bottom line for other hospitals or other facilities?

Councilmember Floreen,
And, finally, with respect to your State Health Plan, does that include criteria such as there should be "X" number of whatever serving "Y" number amount of population? Do you have criteria that establish some baseline against which to judge the need and accessibility criteria?

Paul Parker,
There are standards like that, yes.

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Councilmember Floreen,
So that would guide the decisions on these points?

Paul Parker,
Mm-hmm.

Councilmember Floreen,
Okay. Thank you.

Council President Praisner,
Councilmember Trachtenbeg.

Councilmember Trachtenberg,
I'll be brief. I first want to start by thanking those that have joined us today for what really has been a very comprehensive presentation. And before I came into the presentation, I had a sense from work and conversations even with public health colleagues that the process was thorough. And it's very clear to me from the discussion we're having here that that is the case. I'm actually going to just pose a few questions and ask for some follow-up material rather than take the time; because I know many of us are still waiting and looking forward to having the conversation about the rate setting. I note from my colleagues that in the packet that was provided to us there is a booklet on use of Maryland hospital emergency departments – which is actually really, again, a very comprehensive report about the services in the state and about how needs are assessed. And actually if you go through it, I think it answers even some of the questions that some of us have been asking up to this point. I bring us to pages Roman numeral VI, VII, and VIII. And I would note for Councilmember Knapp that on the first recommendation, there's a very thorough explanation about the conversion of the hospital setting to the emergency setting. And the Germantown project was actually mentioned right there. The first question I actually have is about the chapter of the State Health Plan on acute inpatient services. And I'm assuming that the revision of that is in the works?

Paul Parker,
Yes.

Councilmember Trachtenberg,
And I wonder if you could be so kind as to provide me with a copy of what exists at this point because I think that's relevant as we continue to have conversations here about the function and the needs relating to hospitals and whether we've got adequate hospital sites. The second thing I wanted to actually ask about because I've heard about this from a number of people and the recommendation 9 which is on page Roman numeral VIII; there's mention of a work group around psychiatric needs in the state. And I just briefly wondered, Where are we with this work group? Because clearly one of the charges of this group is to develop projections on bed needs for inpatient psychiatric

services. And clearly, like so many jurisdictions, we have real challenges in this regard because -- as you noted in your report -- we have only one freestanding facility. So I just wondered where we were with that particular work group.

Pam Barclay,
We actually submitted this report to the General Assembly in January of this year.

Councilmember Trachtenberg,
Okay. I didn't realize you had.

Pam Barclay,
This report was an update of an earlier report the Commission did. We did it at the request of the joint budget committees in the General Assembly. And they actually – in the latest budget, the budget that has just recently passed -- they took this report and gave us another assignment, and have asked the Commission to basically head up a comprehensive planning effort for mental health services in Maryland. And we were partnering with the Mental Hygiene Administration and the Transformation Grant to develop a plan for both inpatient and outpatient services for the state. The plan is to be developed with the assistance of a task force, and the membership of the task force is actually prescribed in the Joint Chairman's report. So we are actually working on implementing this recommendation right now.

Councilmember Trachtenberg,
Okay.

Pam Barclay,
And I think we are to report back to the General Assembly in November of this year. So we hope to have some at least some good initial work done on that.

Councilmember Trachtenberg,
Okay. Because I had heard different things, and it sounds me like the expectation is that there'll be some form of a report before the session again begins in Annapolis.

Pam Barclay,
That's correct.

Councilmember Trachtenberg,
Okay, well that's excellent. The last thing I just wanted to make a request on – and, again, I would note for colleagues – specifically, colleagues from the HHS Committee and Councilmember Leventhal who chairs that committee -- that one of the things we might want to actually have you provide us with would be some information on the Commission's function relating to long-term and community-based services. And I am particularly interested in that because as we try to design a responsive hospital system here in the County, clearly one of the things we have to continue to make great investments in are the community-based services that we provide. So I would really be

very interested -- and I would hope my colleagues would be as well -- in having some information from the Commission on that particular –

Pam Barclay,
We'd be happy to do that.

Councilmember Trachtenberg,
Okay. And, again, thank you for coming this morning. I have been sitting here so impressed with your patient and very comprehensive responses to all the many questions you've gotten.
Council President Praisner,
Councilmember Elrich.

Councilmember Elrich,
I want to thank you also for your presentation so far this morning. I've worked with your department and gotten data from it before, and I've always found it amazing how much data you have; and the staff has always been very helpful and, I think, contributed to a very transparent process which I think is very useful. Before I get into the core of my questions, I just wanted to comment on Duchy's comments on the use of Maryland hospital emergency departments. I was just curious as to whether you have this aggregated data by County; since you put this all together, and everything talks about the State. It looked like an enormous wealth of information about a whole variety of things, and I'd be interested in knowing if we could get access to it for just the County data.

Pam Barclay,
There is -- in the appendices to that report, there are some hospital-specific data tables; but we also have a lot of data that certainly we can make available to you by county and by service areas within the county. So as Paul has talked about the patient origin data, we have that type of information available for emergency department services as well. So we would be happy to share that information with you.

Councilmember Elrich,
It's very interesting and very comprehensive. When you determine service areas for hospitals, do they ever change in response to changing need, demand, population; or are they pretty much established and only reviewed when some event triggers the need for review?

Paul Parker,
Well, service areas do change over time In response to changes in service mix and just success in stealing market share from your competitors and that sort of thing. It's typically a gradual change; we don't see rapid changes. And those changes get reflected when we update need projections, for example. So earlier when I was saying later this year we're going to be updating our forecast of hospital bed need, those are actually hospital-specific forecasts of need. They tend to get aggregated and used at the jurisdictional level; but to the extent that service areas of hospitals in Maryland have

changed since 2002 -- which was the base year for our last set of forecasts-- that will change that need projection for example.

Councilmember Elrich,
So you'll be making projections for need for beds by hospital rather than need for beds for Montgomery County?

Paul Parker,
Well, what I meant is that we actually are looking at institutional service areas as the baseline for doing our projection of bed need; but in the plan and in the plan standard, it's aggregated at the jurisdictional level. So we actually produce a bed need forecast for Montgomery County; but that forecast is based on all of the areas from which patients come from into Montgomery County hospitals.

Councilmember Elrich,
You said you are going to update it. Do you know where we are right now roughly in terms of deficit of beds or overages of beds? I remember the days when they were shutting down beds.

Paul Parker,
We've approved additional beds at Shady Grove; and that's the only hospital that's actually applied for additional bed capacity since the Commission has been in the job of giving out more beds – which is only something that's occurred in the last few years. Yeah. For a long time there really wasn't any need for additional bed capacity in the state. And even though census has been going up, the actual physical capacity – the bed spaces, the patient rooms that are available in most hospitals in the state -- still exceeds their licensed bed capacity.

Councilmember Elrich,
Right.

Paul Parker,
So there's been a lot of –

Councilmember Elrich,
an ability to absorb within the existing infrastructure.

Paul Parker,
Right.

Councilmember Elrich,
Am I also correct in assuming that if there's a rough match between the 7.9% increase in utilization and a similar increase in population – I know the numbers from 2000 to 2006 were 6.6%, so it's probably another percent and something for 2007 – so you show about a 7.9% increase in utilization. So we're basically not looking at a trend in increased utilization by the population, but we're looking at a similar per capita utilization

of hospital beds. Or is the growth matching the population growth -- as opposed to a trend of putting people in the hospitals more often?

Paul Parker,
Montgomery County actually, even on an age-adjusted basis, tends to use hospital beds at a lower rate than the overall state average.

Councilmember Elrich,
Yeah. Okay.

Paul Parker,
One thing that you need to understand about Maryland, too, is we have what I call "dynamic hospital licensure" which means that every year your license gets adjusted based on the last 12 months of utilization. That's something that happens independent of CON, even though we actually put that number out there. And hospitals can operate up to their licensed bed capacity, even if that goes up on the annual change in licensure without getting a CON. So if I can put 300 beds in my hospital, and my current license capacity is 250, that means I'm going to have excess space in my hospital where I could house patients; but I can't because I'm only licensed for 250. If your census goes up, then the next year your license capacity may go up to 260; you can now put 10 more beds into operation. So even though we haven't added very many beds in Montgomery County; and, as you said, we've seen this like an 8% increase in census, more hospital beds are being put into operation in Montgomery County because hospitals have the physical capacity to do that. And as their license goes up, they can do it.

Councilmember Elrich,
Will you be able to give us information on the difference between physical capacity for beds and actual capacity for beds? Is that something you have?

Paul Parker,
We can do that. One caveat though is when we have CON applications, we get a very precise view of what a hospital's physical bed capacity is. If a hospital hasn't filed an application in a number of years – and some haven't – they tell us what their physical bed capacity is; but we don't actually go in and count beds and survey to verify that. So in some hospitals, we know absolutely; on others, we have a number. It may or may not be that precise in terms of physical bed capacity.

Councilmember Elrich,
When you look at future projected need, do you take into account, for example, the County's projected growth and areas of growth? For example, for you to determine that based on the numbers of growth, that we were to need X number of additional beds, would you look at where those beds were potentially located? For example, if you were to experience or anticipate heavier growth in the northern part of a region; and an application came in and said "Well, we're getting this growth in the County. It raises the demand for beds, and we want to put beds in the southern part of the region, allowing that total number of beds to increase." And by adding them to the southern part of the

region might make it then difficult in the future for somebody to come in and put a hospital more closely aligned with where the population growth is, would you consider that in allowing the hospital to have beds or not?

Paul Parker,
That is a consideration in a multi-hospital jurisdiction like Montgomery County. We will have a jurisdictional bed-need forecast that is kind of the starting point for a CON application; but then, again, when we actually get an application, we're going to be looking at, Okay, what is the particular service area of this hospital? What is the appropriate share of bed need that should be allocated based on the differences in how that service area is projected to grow versus other parts of the County?

Councilmember Elrich,
So how would you weigh the potential impact of the closure of Prince George's Hospital on the County? How would you look at it in terms of our service areas and our patient need? Are you anticipating that, or will you not anticipate it until it happens?

Paul Parker,
Well, we spent a lot of time trying to anticipate it this spring; and it didn't happen. And we were looking at what would be the likely scenarios as far as impact on emergency departments and bed capacity at surrounding facilities, and then included Montgomery County's hospitals. If it actually closed down and was closed for some period of time, that would change, obviously, the patterns of patient care and would affect our projections of need that would actually come into play in different areas. In that particular case of Prince George's County, we were looking at some pretty dramatic and difficult types of impact where we recognize that we might need to take some sort of extraordinary actions in terms of dealing with possible CON issues and facility changes to accommodate the shift in demand.

Councilmember Elrich,
Is that information that can be shared with us, so we have a sense of what we might be staring at?

Pam Barclay,
We did some work with a group of work groups that were put together to look at, earlier this year, the various services that would be impacted. We did pull together some data on that impact which we can certainly share with you. One of the work groups on obstetrical services was actually chaired by a couple of the staff people at Holy Cross Hospital because they're such a major provider of obstetric services. So we do have some of that information that, of course, we would be glad to share with you on impact.

Councilmember Elrich,
Okay. How do office buildings fit into your consideration, or don't they? Does the hospital need a Certificate of Need for a medical office building, or is the medical office building outside the Certificate of Need process?

Paul Parker,
For the most part, outside because it's not a regulated type of hospital service. They're not going to get -- correct me if I am wrong – they're not going to get any sort of accounting in their rate structure for the cost of building a pure medical office building on their campus. We do see projects that include physician office space because they're building, let's say, a big ambulatory care building on their campus which includes a number of clinical services that are regulated and puts them under CON. But then there's also some office space as well. But we're not typically focusing on answering need questions about that because it's not clinical space.

Councilmember Elrich,
So we could --if we were dealing with a proposed expansion and it combined a mix of medical office space and hospital uses -- separate buildings assuming – it would be fair of us to say that the assumption of your approval of a Certificate of Need for the hospital services is independent of any comment on the medical office building. In other words, the medical office building doesn't come part and parcel along with your approval of a particular hospital use?

Council President Praisner,
Marc, if you wouldn't mind, I'd like to move to the Rate Process issue presentation; and then I'll come back to you.

Councilmember Elrich,
One very last question?

Council President Praisner,
Well, quickly please.

Councilmember Elrich,
How do you evaluate -- when an applicant says, "We looked at alternatives," how do you evaluate that statement? Do you actually go out and -- what level of proof, what level of evidence do you require for that evaluation?

Paul Parker,
Well, they can't just stop at that point; we want the details. Okay. What were the alternatives that you looked at? How much did you estimate they would cost, and how did they compare with the project that you've asked approval for? How do they compare in terms of achieving the objectives that your chosen project is going to achieve? What are the differences in effectiveness? We'd like people to do a very comprehensive, conventional cost-effectiveness analysis where they basically look at the alternatives that meet or partially meet the same objectives, and actually cost those out for us and actually come up with a reasonable way of measuring effectiveness so that we actually have cost-effectiveness ratios. A lot of times we don't get that, but we certainly push applicants as much as possible to give us as much meat on those bones as possible.

Councilmember Elrich,

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Thank you.

Council President Praisner,
Okay. Let's move, can we please, to the second presentation. We may have interrelated questions; I know mine are. So, Mr. Murray, if we can proceed.

Robert Murray,
Okay. Great. Thanks, Madame Chair. In the interest of time, I'm going to step through this pretty quickly. I have an engagement that I'm afraid I'm going to have to leave for.
Council President Praisner,
That's okay. We have scheduled fudge time into this. So go ahead

Robert Murray,
Okay. Just to, I guess, have Whitney try to keep up. The first slide you can see the configuration of the Commissions within the state. The HSCRC is the rate-setting Commission. We've been around since 1971. We're a sister Commission to the MHCC. We, along with the Department of Health and the Maryland Insurance Administration, kind of form the regulatory structure; and we all report directly to the governor. So we're not underneath the Health Secretary. Just very quickly, characteristics and jurisdiction of the Commission. It's an $11 billion hospital industry in terms of overall revenue. It's the only all-payer rate-setting state in the nation. There were previously four others; and there are no longer, obviously. We regulate 47 acute care hospitals under all of our rate-setting jurisdiction, 3 chronic and 3 private psychiatric facilities. Our jurisdiction relates to inpatient services -- acute care inpatient services as defined by Medicare -- and outpatient services that are provided at the facility itself. So we don't regulate these freestanding centers that had been discussed earlier. We also regulate emergency rooms at hospitals themselves, and there's no regulatory authority over physicians. The next slide. I've already talked about we started in 1971; we started setting rates in '74. The system became all payer. We brought Medicare and Medicaid into our authority for setting rates in '77. And the founding legislative goals have applied throughout that period of time and apply today. And they're really these four – maybe a fifth: controlling costs, trying to improve access to care, making sure that there's an equitable payment system, ensuring financial stability and predictability in the system, and then the last that's not on here is public accountability. Our system is really based on what's been referred to as "a public utility model of regulation." We have an essential service. There's a need for access to that essential service, but there's a potential for monopoly power to be exercised within the marketplace itself. So under that rationale, there's a role for a regulatory body to try to correct for market failure, promote competition, and assure access to that service. We're a seven-member volunteer Commission. As I said, those commissioners report directly to the governor. We're politically legally independent, and our law has been very broad. It's given us flexibility in terms of how we've crafted our policies. The legislative authority, as I said, applied to the inpatient/outpatient services. It applies to all payers. I just wanted to emphasize that point. It applies to Medicare, Medicaid, Blue Cross, all HMO's, all private payers. And again, it's the only state to have a system like this. Next slide. Talk a little bit about those four goals that I mentioned before – how we've done on that. We've had the

second lowest rate of growth of any state in hospital costs over the period that we've been regulating rates, '76 to 2005. Definitely better access to hospital care than any state; I can say that unequivocally. We build in an excess of $800 million into the rate structure of the hospitals collectively to provide a financial incentive for them to treat the uninsured. It's the most equitable payment system, and I'll talk a little bit about that in a minute and try to illustrate what that means. There is a high degree of predictability within the state for hospitals, and their operating and their financial circumstances. We also have a lot of data and information that's all publicly available. Just very quickly, graphically to try to illustrate some of these things. You can see the rate of growth of hospital costs nationally -- that's the blue line. Since the beginning of the system, we've grown more slowly and generated pretty significant savings for the State. And, in fact, over the life of the system, we estimated we've saved the State $32 billion. Had we grown at the rate of hospital costs nationally, there would have been $32 billion more hospital expenditures in the state. Try to go to the next slide; it shows uncompensated care -- the amounts that we put in, in terms of overall dollar amounts on the left-hand side – in excess of $700 million. We're up over $800 million of financing uncompensated care in the state. That's equating to about 7% to 8% of hospital revenues. Maybe move to the next chart. This illustrates the all-payer aspect and the equity aspect of the system. The left side of the chart shows the situation in other states where you get a myriad of charging practices and payment levels across the different payers. Uncompensated care/uninsured will pay the lowest amount -- whatever they can afford --and there's a shortfall for the hospital. Medicaid will pay below costs generally in other states, and there's a shortfall for the hospital. Medicare pays at or below cost. And then the hospital's left with trying to shift those costs to other payers by jacking up their charges by anywhere from 150% to 200% above their costs. And then it's a shell game, where the private payers will try to negotiate discounts off those artificially inflated charges. In Maryland, because of the all-payer system, it's one rate for a given service at a given hospital that all payers will pay. And you don't have this elaborate cost-shifting game that takes place. And you can see it's a much more equitable system. And our mark-ups over cost are uniform; and they're much, much lower. We have the lowest mark-ups of charges over costs of any state, and they're considerably below that of the U.S. If you turn to the next graph, this is a chart that was done by MedPAC, which is the Commission that advices Congress on Medicare reimbursement nationally. You can see the markups nationally have grown from 20% up to over 150% posted charge, whereas in Maryland they've stayed relatively constant. Part of that markup is that provision for uncompensated care that I mentioned, the 8-9% that we build in. Now, the next slide shows all of this is made possible by the Medicare Waiver. It's a waiver that we have from federal reimbursement methodologies. Medicare in Maryland pays hospitals on the basis of the rates that our agency establishes; whereas Medicare will pay other hospitals outside of the state, obviously, based on their own methodologies. It's the only state to have a waiver of this nature. It's in federal statute, so it would take an act of Congress to take it out. There are two tests that we must pass to maintain the waiver. One is a financial rate of growth test that the federal government administers on a quarterly basis; and the other is that the system remain all-payer – that we don't allow the discounts for any class of payer. Turn to the next slide. Just very briefly, the benefits of the waiver. It allows for this interpayer equity that I illustrated with that one chart. And

it means basically all payers are contributing equitably to the costs of hospitals within the state, and that includes the cost of uncompensated care. So Medicare is picking up – they're about 45-50% of the market. They are paying for 50% of the uncompensated care in the state of Maryland. It's a tremendous benefit. It allows for -- in addition to this equitable financing of uncompensated care – it gives us a tremendous amount of autonomy so that we can address local issues within the state. It also gives us a high degree of predictability because we determine the rate of growth of hospital rates over time, and that ensures the financial stability and also helps us meet whatever fiscal goals we're looking to meet. If you turn to the next page, talk a little bit about – at least list off some of the other projects that we're working on. In addition to setting rates, we will be the first state to have an all-payer, pay-for-performance, quality-based reimbursement system. That will affect not only all payers, but all hospitals. Quality of care, of course, is very important. It's something that a lot of people are devoting attention to nationally/internationally. Maryland is the only state that can apply it across the board. Elsewhere it's fragmented by health plans, Medicare, Medicaid; here it will apply to everyone. We also have the first bundled outpatient payment structure in the nation, and probably internationally as well. We provide in excess of $18 million per year in the nurse support program to try to address the nursing shortage. We also subsidize the Maryland Health Insurance Program, which is the high-risk pool. There's an assessment on hospital rates to provide funding for this high-risk pool which insure the medically uninsurable. There is also a community benefit report that we're charged with authoring every year, and that's on our website. There's a program called the Bond Indemnification Program which would come into effect if there was a hospital that would become closed or -- this program is geared toward paying off the public body obligations of the facility that is closed or delicensed. We also have an HSCRC Hospital Pricing Guide which is available on the web. Just to wrap up – very quickly, again, we were established to address these goals: the cost, access, equity, financial stability, and accountability. I think we've done a pretty good job. There's certainly weaknesses to rate setting, and I'll be glad to talk about those as well; but overall, I think we've got a pretty sound system. The system is "prospective," meaning that we set rates at the beginning of the year; and those are the rates and the standards that the hospitals have to meet. So they do incur and encounter some degree of financial risk, albeit they know what they're in for – they know what their standards are. They know what targets they have to meet. Outside of Maryland, it's anybody's guess. Our role is to try to correct for market failure, but we're not monolithic in our approach; we're very macro oriented because we're a small agency. We're only 28 people, but not monolithic. There's a lot of subjectivity. There's meetings. We deal a lot with the hospitals' unique circumstances and issues and try to address them. We don't always say "Yes" to their requests, but at least there's a forum for hospitals to come in and chat with us and the Commission. Then lastly the regulatory approach, as I said, be focused on local issues, solutions to local problems. We try to promote the social mission of hospitals: that's financing uncompensated care, providing access, also funding for graduate medical education, and community support. There's this emphasis on fairness and consistency in approach. We try to minimize regulatory intervention. I mean all of this is complicated, but really it's done at a very high level in terms of the standards and targets that hospitals have to meet. There's a high degree of focus on public accountability. I've

already mentioned the prospective nature of rate setting. And then an emphasis on trust and cooperation. I do have some additional slides here, but I thought we could focus on specific questions.

Council President Praisner,
If you just want to talk about what these slides in general say. I think that would be helpful, and councilmembers can look at them.

Robert Murray,
Sure. Well, there is a community benefit. There's some information that talks about our legislative charge there; and that information's on the web, and you can peruse those slides. There's also a couple of slides on our rate-setting methodology which, I think, are somewhat self-explanatory. It's a hybrid methodology that employs both diagnostic-related groups or DRGs, if you're familiar with that classification. But also we have a fee-for-service rate structure that we approve for as well for individual hospitals. So it's a combination of the two. And then, lastly, there's a slide -- or two slides on data. We have a tremendous amount of data – both case mix data, which is clinical/financial/demographic data on every patient, both inpatient and outpatient, as well as extensive financial data as well as financial statements for every hospital.

Council President Praisner,
So If I were to ask for information on the demographics of Montgomery County residents who may be using Prince George's hospitals, you could provide that information for us?

Robert Murray,
Yes. And it's also very timely. Data for a given quarter available to the Commission 45 days after the end of that quarter. So we're working on data through March of 2007.

Council President Praisner,
So if you would follow up on that that would be very helpful.

Robert Murray,
Sure.

Council President Praisner,
Thank you. Okay. We do have some councilmembers who would like to follow up with questions. I'll start with Councilmember Ervin.

Councilmember Ervin,
Thank you very much for your report. I didn't know that Maryland was such a leader in this area. That's really interesting to know and to hear about. I have just one quick question really. I represent a district with two hospitals that have a significant level of uncompensated care, and they have to pay doctors to provide on-call emergency room

coverage and also elsewhere in the hospital. Does the rate-setting system reimburse hospitals for those costs?

Robert Murray,
Originally we had hospital-based physician under our authority; but there was a legal challenge, and we lost the legal challenge in circuit court. So as a result, that authority no longer resides within the Commission. So the quick answer to your question is, “No” We don’t have authority to set rates or provide reimbursement levels for those types of providers. As a result, the hospitals do need to oftentimes pay excessively, I think, in monopoly rents to ensure that those physicians remain at the facility, although the hospitals here are quite financially profitable even though they're nonprofit facilities. But they do generate margins, and they do pay for retaining those physicians out of their surpluses.

Councilmember Ervin,
Even the hospitals that we’ve been hearing from that do take care of a lot of patients who have no insurance -- those hospitals, according to you and your data, are still doing financially well?

Robert Murray,
Oh, yes. The margins are quite robust across the board. And actually the hospitals that treat the highest levels of uninsured --that is financed through the hospital rate-setting system. Unlike in the rest of the country where there is no reimbursement, that’s paid at a rate of 98-99-103%. It varies from year to year, but it's paid for. Now, what's not paid for are the reimbursements – there are no reimbursements to the physicians that have to cover, so that's where the shortfall occurs. But at the facility side, they are paid for absolutely.

Councilmember Ervin,
Thank you.

Council President Praisner,
Councilmember Leventhal.

Councilmember Leventhal,
Thank you, Madame President. I’d like to invite Mr. Murray back to the Health and Human Services Committee because I have so many questions, and I’m not going to ask any of them. I’m going to make a short statement. So we have a pretty ambitious effort here – a County-based effort -- to provide primary care to uninsured residents. So what I’d like to do in the relatively near term -- and it may be September before we can get to it -- is invite you back in order to get into even greater depth as to rate setting, reimbursement for uncompensated care, how that works, how our system might interact with that and to get into greater depth there. So I’ve got a million questions; I'm not going to ask them right now. What I’d like to do instead is use this time before we close –

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Council President Praisner,
Well, we still have questions.

Councilmember Leventhal,
I'm sure we do. No problem. But I'm going to wrap up. I just will say what I have to say, and then I won't turn my light on again. I'm just going to sort of get back to the first presentation. So again, to Mr. Murray – I'd like to see you again, and again and again; because you've laid out some issues that are of immense interest to me. And so the fact that I'm getting back to the first presentation doesn't in any way mean that we didn't benefit from the overview of rate setting; but it's very complex. And I don't think we have the time to do that justice here.

Robert Murray,
No. Absolutely. I understand.

Councilmember Leventhal,
So I hope we can schedule some time as soon as possible to get back to the issue of rate setting. I want to state very clearly that I don't believe that Montgomery County has the information that we need to fulfill what I think our community is going to expect us to do to participate in the Certificate of Need process. And so what I would like to do immediately -- and I know schedule is tough. I know that councilmembers are busy. But what I would like to do as soon as we can -- in June or early July -- is to put on the HHS Committee's agenda a discussion of how we participate in the Certificate of Need process and how do we compile the necessary information to participate constructively in that process. And my view is this. Given that there is a very clearly defined role for a County Health Department, I don't believe it is appropriate for us to step back and leave it to the State to determine what the correct answer is with respect to these various applications for certificates of need. In saying so, I recognize that I may be, regretfully, in some disagreement with my friends in the executive branch; but I do think that this Council needs to find a way to compile the necessary analytical information in a very near-term way. And I don't think we can wait until the fiscal '09 budget process to do that. And I don't think that these issues related to applications for certificates of need, need wait for all of the other information that we were talking about during our discussion of the Community Health Improvement Project. So although I remain very interested in identifying health disparities and identifying issues of cultural competency and identifying issues of various constituencies and their need for health care and the status of different diseases in the County and all of that, it is my view that we should segregate the issues related to the applications for certificates of need that we know are coming, and assemble the analytical information that will be necessary for us to weigh in constructively in that process. I think we need to do that in a very near-term way. I anticipate that it will cost money. I believe that the Council needs to identify the cost and the parameters of assembling the analytical information we should need. I know that different councilmembers have a variety of approaches, and that there are several different certificates of need pending involving a majority of our hospitals – not just one. So I would like to schedule that very soon. I just don't think we're in a position – I don't

think we're where we need to be as a County to participate constructively in that process.

Council President Praisner,
George I appreciate that. My view though is that the full Council and Executive have not yet determined what, if any, or if there are differences of opinion as to what or how we would respond. And while I appreciate the HHS Committee scheduling a discussion, it should not automatically assume that there is unanimity among the Council or between the Council and the Executive as to what that approach should be. So I would appreciate the Committee looking at options for the Council's consideration rather than making an automatic judgment as to what approach will be used.

Councilmember Leventhal,
I appreciate working with the Council President at all times. I very rarely assume unanimity on the part of the County Council.

Council President Praisner,
Well, or even majority is my point.

Councilmember Leventhal,
I don't assume ahead of time that there would be a majority. And I'm well aware that if money needs to be spent and that if it is not requested by the County Executive, that it requires six votes from this body. I'm aware of all those things, so look forward to continued conversation. But my bottom line remains, We, as a County, don't know what I think we need to know. And I think there is significant urgency and significant time. We have about a year – a little less than a year -- to weigh in constructively. It is very clear to me that there is a role for Montgomery County, and I don't think we know what we need to know to play that role effectively; and so I want to begin discussing that right away.

Council President Praisner,
Right. My only question was in laying it out, it should be laid out as approaches to the issue of how we respond and what we need to know. Because I think that would be the most helpful in generating views that may range -- and also assessments of what the costs might be to respond to what we ultimately do.

Councilmember Leventhal,
I agree with your last comment very strongly. I'm not prejudging the outcome of how we assemble the information and what questions we ask. I'm not prejudging that at this time. But we need to begin pulling that together right away.

Council President Praisner,
Councilmember Andrews.

Councilmember Andrews,

Thank you, Madame President. Thank you all for your presentations. I was very impressed with the results that have been produced over the last thirty years by the Health Services Cost Review Commission: the second largest growth rate of any state, better access to hospital care of any state, most equitable system, relative financial stability, and public accountability. I don't like to assume anything, but I hope that there's no prospect that's going to be – the Cost Review Commission is facing challenges in terms of its own work. It seems like you're doing a great job. My question is, you said the Medicare Waiver is what's made this possible over the last 30 years. What's been going on in other states? Why aren't other states doing this? Are there political obstacles in the states? Interest group lobbying? Not approval from federal government? What's going on?

Robert Murray,
I think it gets down to a couple of things. One, it's serendipitous that we were able to negotiate this waiver. We negotiated it at a time when Medicare was paying much higher in Maryland than they were nationally. So there were federal dollars coming into Maryland relative to national average payment levels, but they agreed to give us the waiver as long as we flattened out the slope of that curve. So that's the waiver test. It's a cumulative rate of growth test. As long as we keep the slope flatter than that of the nation, we keep it. We're still above the U.S. So there's over $700 million coming in from the feds relative to what they would pay outside of Maryland. So we were lucky; and the folks that started this system were very good negotiators. And we've been able to keep the system in place. The waiver test is not a test of affordability because Medicare pays over 20% higher here than they do nationally. But we've tried look at other things to keep things more affordable here. Since that time, budgetary issues -- the feds haven't been willing to grant the same sort of arrangement. In various states, there may be interest groups that are against that type of thing. If payers are dominant in a particular state, they don't want rate setting. If the hospitals are dominant, they don't want rate setting. So it really is a combination of the political dynamic and also pure luck.

Councilmember Andrews,
And good negotiating. And it's in law, you said.

Robert Murray,
Yes, it is. We're the only state to get it into federal statute.

Councilmember Andrews,
Good work.

Robert Murray,
Well, I congratulate my predecessor.

Councilmember Andrews,
Yeah. Thank you.

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Council President Praisner,
Councilmember Elrich.

Councilmember Elrich,
So it's good to be lucky in this case.

Robert Murray,
Sometimes better than being smart.

Councilmember Elrich,
Sometimes, yes.

Councilmember Floreen,
Nice is good too.

Councilmember Elrich,
Couple of quick questions. Can a hospital appeal uncompensated care if they don't agree with the finding of the Commission?

Robert Murray,
Yes, and oftentimes -- quite often as a matter of fact -- those are the subjective conversations that we have with facilities. They'll come in and say, "Your methodologies don't really pick up these unique circumstances. Take a look at this. See if we have an argument." And we do consider those things.

Councilmember Elrich,
Have Montgomery County hospitals – any of them -- appealed their uncompensated care recently?

Robert Murray,
Not recently to my memory.

Councilmember Elrich,
So not in the last few years?

Robert Murray,
No. And as a matter of fact, in the period – I'm not sure how it stacks up now – but in the period '04/'05 and maybe '06, we overfunded most every hospital in uncompensated care. There's a cycle to it because we use historical data.

Councilmember Elrich,
Right.

Robert Murray,
So when uncompensated care is going up, we tend to under fund it. When uncompensated care goes down, we over fund it because we're using data that are

showing uncompensated care levels as being higher. So that may also account for the reason why not many have appealed their provisions.

Councilmember Elrich,
Okay. And is it fair to say that Prince George's General was tripped up by uncompensated care?

Robert Murray,
Hm-mm.

Councilmember Elrich,
Okay. My follow-on was going to be, If so, is that a threat to the County or the hospitals here?

Robert Murray,
No. I think – well, certainly they do have more challenges than other facilities for the reasons that Councilmember Ervin mentioned -- the fact that their physicians generate more uncompensated care. So that there's a higher burden there for them. But the facility itself is made whole for their uncompensated care. Any hospital payments are paid for in essence. Now, we do put extra amounts into their rates; so that might bring their prices up a little bit higher. But there is a pooling mechanism that will account for that. It gets a little complicated. But very quickly, if their uncompensated care levels are 15%, we'd normally build 15% into their price. But we pool money from all hospitals and then provide them money out of that pool to bring the amount in their prices down to 7%. That 7% is comparable to all the other facilities in their County; so they're not at a competitive disadvantage in terms of their pricing. And that's a misperception that you hear a lot from the folks at Prince George's and in the County. They think that they are competitively disadvantaged because they've got so much money in uncompensated care; that's not true. So that's why I reacted the way I did, is generally uncompensated care is not what has created the biggest challenge.

Councilmember Elrich,
So you don't see it as circumstances today or trends that are threatening in terms of uncompensated care toward County hospitals?

Robert Murray,
No, I don't because of the rate-setting system.

Councilmember Elrich,
Okay. Thank you.

Council President Praisner,
I just have a couple of questions. Try to relate the two together. In the Certificate of Need process, one of the criteria for evaluation – again, I apologize for my voice -- is cost-effectiveness. How do you define cost-effectiveness, and how does that relate to the rate structures of the hospitals where the status of the, again, uncompensated or

service area issues? And is the cost-effectiveness criteria related to the proposal only or to the cost-effectiveness of that hospital as it currently exists?

Paul Parker,
We look at cost-effectiveness. First of all, I should say that we try to focus on cost. In other words, what is the hospital expending in order to undertake a project, and what will be its operational cost of providing service in the platform that it's creating with its capital investment? So we're not looking at charges.

Council President Praisner,
Okay.

Paul Parker,
We're basically saying, If we can look at the investments that hospitals are making and try to assure to the best extent that we can that they are actually spending their dollars to create the most efficient and effective way to provide services, then Bob will take care of the charge side of it. He'll keep the charges in line. If we can keep the cost as low as possible, then charges – if we have an effective rate-setting structure, charges should follow that.

Council President Praisner,
So you're looking at the stand-up of the proposal -- the cost of the proposal from a construction, from the facility kinds of issues. You're not looking at cost from a rate piece at all.

Paul Parker,
From a payer standpoint, right. We're not looking at charges. We're looking at how much the hospital is paying to do what it wants to do. And it's not just the capital project.

Council President Praisner,
And it's making the assumptions about return, part of which is an assumption of rate, though, and population; isn't it?

Paul Parker,
Well, we get into another criteria, which is financial feasibility.

Council President Praisner,
Okay.

Paul Parker,
And there, of course, obviously we want to see that the hospital is going to be able to garner reimbursement and payments that will cover its cost of not only doing the capital investment that it wants to do, but then also providing the services in the future. But on specific criteria and cost-effectiveness, we're looking at the inputs that are going into doing a project. Not only the capital inputs, but because there are different ways of doing capital projects that meet the same kind of objectives, the different alternatives

may have different operating costs implications. So we try to also look at the operating cost implications of different alternative ways of doing a project. And actually, those are sometimes going to be more important than the capital costs because those are a much bigger cost over time. And we want to see that hospitals that are really doing major modernization and updating of their facilities are not just considering, "What do my doctors want?" and "What would be the state-of-the-art?" based on whatever the latest magazine says. We want to make sure that they're really looking at, "What is going to give me the facility that's going to let me operate as cheaply as possible and as efficiently as possible and minimize my operational costs?" And when you're modernizing a facility and these modernizations are occurring in an environment where actual volume of service is increasing, we try to emphasize that you guys really need to be looking at economies of scale and trying to get your unit costs down as you modernize these facilities. So we really try to focus on operational costs as well as capital costs.

Council President Praisner,
How frequently can a rate be modified for a hospital?

Robert Murray,
Generally, we do it on an annual basis. And, very quickly, in terms of how we set rates, we'll set base rates for all hospitals as we did back in the 70s. And then it became a prospective system of just updating those rates. And our regulatory influence is on the slope of that curve over time. And we act as a competitive market would act.

Council President Praisner,
So a once-a-year kind of process?

Robert Murray,
Yes. Right.

Council President Praisner,
So if a hospital finds itself in a certain situation in the middle of the year, it still has to wait?

Robert Murray,
No. Well, there is an appeal process that hospitals do have. They generally don't take advantage of that. They generally operate under that prospective system of rate updates; but they can file for full rate reviews to have their entire rate base reset, and there's a methodology associated with that. So, yes, there is an appeal process.

Council President Praisner,
Can you any of you comment on the issue of mergers and the restructuring of hospital systems – hospitals I should say -- from a standpoint of ownership and sharing or developing partnerships or relationships within the state? What may be happening, if anything?

Robert Murray,
There was a big push for consolidation in the mid- to late 90s sort of following the latest trends that seemed to be in vogue nationally where hospitals were starting to consolidate and try to vertically integrate. That took hold a little bit here. You saw MedStar form. University of Maryland has reached out. It sort of died down for a period of time; and then most recently, University of Maryland has started to acquire facilities – Shore Health System. And then I guess there have been discussions about Montgomery County here as well. Now, the other states –

Council President Praisner,
What role, if any, do you all have either way -- in that merger/restructuring kind of thing? Is it a Certificate of Need issue at all? No.

Robert Murray,
It's largely just notification that's required of the hospitals. They need to notify that there will be merger a merger – announce the merger.

Council President Praisner,
But the financial viability, does that not then become a factor in looking at – you know, is your CON, as structured, more financially viable or not?

Pam Barclay,
Well, yeah. Generally those types of mergers and the more recent affiliations have been more in an acquisition type of mode. That does not require Certificate of Need approval provided that the services are not changing.

Council President Praisner,
Okay. So it's only the service issue – which is what you're regulating with the CON.

Pam Barclay,
Right. So it does require notice to the Commission, but it doesn't require our review and approval.

Council President Praisner,
I think it was in your folder that you made – your presentation -- the comment was made, There are no public hospitals in Maryland. Quite often I hear folks misunderstanding, and I've heard dialogues back and forth of differences of understandings of Prince George's system because the Prince George's government at one point held the CONs. So would you –

Robert Murray,
They held the CON –

Council President Praisner,

The State held the CONs for Laurel. And then when the Prince George's Bowie/Laurel structure was put together, the CON was held by the Prince George's gap.

Robert Murray,
Right.

Council President Praisner,
So explain to us the actual – because we hear comments – the actual Prince George's County Government relationship with the Bowie/Laurel and Prince George's General.

Robert Murray,
They own the assets.

Council President Praisner,
They own the land, and they own the buildings?

Robert Murray,
Yes, they own the buildings. There are some assets that are owned by Dimensions Health System, but then Dimensions leases those assets for a dollar a year.

Council President Praisner,
And Dimension took them from HCA years ago?

Robert Murray,
Yeah, I believe so. I was in high school.

Council President Praisner,
Okay. Thank you. Thank you for making me feel old. ((Laughing) Okay. So from a standpoint of the evaluation of what's going or the status, that is not a public hospital?

Robert Murray,
It's really not. They could very – not usually – but certainly they could operate as other facilities -- University of Maryland had been a public facility and converted to become a private facility and has been profitable. Bayview was the old Francis Scott Key – the City Hospital. There's a circumstance exactly analogous there. They have the same opportunity to operate as a nonprofit, but profitable and financially viable institution and not be labeled as a public facility.

Council President Praisner,
Okay. And so the last question I have is, When we see data from you, is all the data by jurisdiction based on – so it's as Montgomery County? It's not service areas where they overlap into other jurisdictions -- it's Montgomery County geography data?

Robert Murray,
What type of data are you referring to -- like the patient-specific data?

Council President Praisner
Right.

Robert Murray,
Could be zip code of origin.

Council President Praisner,
Okay.

Robert Murray,
So you could boil it down into the zip surrounding a given hospital to generate the patient origin information for a hospital. You can drill it down pretty far.

Council President Praisner
Okay, good. So then we can get the kind of information that we need. All right. I don't have any other questions at this point. I want to join my colleagues in thanking all of you for coming and for making yourselves available and for providing – I think across the board – an outstanding presentation to us that's very informative, very factual, and you've been very forthcoming in your answers. We are in recess until 1:30. Thank you.

TRANSCRIPT

June 19, 2007

MONTGOMERY COUNTY COUNCIL

Councilmember Marilyn Praisner, President
Councilmember Michael Knapp, Vice-President
Councilmember Phil Andrews
Councilmember Roger Berliner
Councilmember Marc Elrich
Councilmember Valerie Ervin
Councilmember Nancy Floreen
Councilmember George Leventhal
Councilmember Duchy Trachtenberg

Council President Praisner,
Good afternoon, ladies and gentlemen. This is a Public Hearing on Bill 8-07, Capital Improvements Program – Bicycle and Pedestrian Impacts, which would require the Office of Management and Budget to submit pedestrian and bicycle impact statements with certain capital projects in the Capital Improvements Program; authorize the Council to require other County departments and agencies to supplement the impact statements furnished by the Office of Management and Budget; repeal obsolete provisions, and generally amend County law regarding the analysis of transportation and other capital projects. A Management and Fiscal Policy Committee worksession, is tentatively scheduled for June 25th, at 9:30 a.m. Persons wishing to submit additional material for the Council's consideration should do so by the close of business Wednesday, June 20, 2007. We have one speaker, Bruce Johnston, for the County Executive.

Bruce Johnston,
Good afternoon, Madame President and members of the County Council. My name is Bruce Johnson. I am the Chief of the Division of Capital Development in the Department of Public Works and Transportation. I'm testifying today in support of Bill 8-07, Capital Improvements program – Bicycle and Pedestrian Impacts. The Department of Public Works and Transportation is committed to improving pedestrian and bicycle safety through the design and construction of our projects in both transportation projects and building projects. We currently prepare pedestrian/bike ADA analysis sheets at the beginning of each project, and our project managers and designers utilize this information throughout the design process to ensure that safety considerations are implemented in the project. Copies of typical pedestrian/bike ADA analysis sheets are attached for your information; and each analysis considers issues such as connectivity between the project and nearby destinations, master plan recommendations, existing conditions related to pedestrian/bike and ADA safety, recommended improvements, and additional costs or impacts to the project. DPWT and DCD will continue to utilize these reports to improve bicycle and pedestrian safety in and around our projects. Thank you for the opportunity to testify.

Council President Praisner,
Thank you. There are no questions or comments, so this completes that Public Hearing. Thank you, Bruce. Good afternoon, ladies and gentlemen. This is a Public Hearing on a Resolution to approve comprehensive revisions to the Office of Zoning and Administrative Hearings' Fee Schedule. Action is scheduled following the hearing. Before you begin your presentation, please state your name clearly for the record. There are no speakers. This is a resolution that implements the fee revisions for the Hearing Examiner's Office that the Council considered during the budget deliberations and is built into the actions that we took on the Capital Budget – Operating Budget I should say. So I would entertain a motion to approve the resolution.

Council Vice President Knapp,
So moved.

Council President Praisner,
Council Vice President Knapp. Is there a second? Councilmember Trachtenbeg. All in favor of approving the resolution, please indicate by raising your hand. (Show of hands) It is unanimous among those present. This is a Public Hearing on a Special appropriation to the FY-07 – Oops. Nope. I'm missing one. Here it is. This is a Public Hearing on a Resolution to approve revisions to the Board of Appeals' Special Exception Filing Fees. Action is scheduled following the hearing. There are no speakers for this. This also is a Resolution that implements the Board of Appeals' Fees Schedule. Change is consistent with Council action during the budget. There is one correction that I would like to make to the packet the Council has in front of them. The packet does not include revisions to the Board of Appeals' Fees Special Exception Filing Fees in those cases when a telecommunication facility is being requested where a special exception is required. The change in the fee would go from the $12,500 to $13,750. It's reflective of the kinds of conversations we've had in the past. So I would entertain a motion with that amended to the Resolution so that the Council can take action. Is there a motion?

Councilmember Leventhal,
Move for approval.

Council President Praisner,
Councilmember Leventhal; second by Vice President Knapp. All in favor of the resolution? (Show of hands) That is unanimous among those present. Thank you. This is a Public Hearing on a Special appropriation to the FY07 Capital Budget and amendment to the FY07-12 Capital Improvements Program of Montgomery County Public Schools for Northwood High School access improvements in the amount of $350,000. Action is scheduled following the hearing. I saw Mr. Levchenko. I think the packet is fairly clear that from the first time the Council had this discussion it's now been determined that there are a variety of modifications, including the traffic signal, but that the traffic signal installation is of concern being installed without those other modifications. Staff is recommending that the Council approve the $350,000. At this point, I would allow the comprehensive actions to move forward and would allow the engineering work for those improvements to be done. They're traffic improvements, even though the traffic signal may not be installed during the summer. I want to report to my colleagues that the community and the school community meeting – the principal and staff and also the PTA and neighboring community -- have been involved in this process and is aware of that modification. And we will continue to get Northwood issues through the next CIP. But this access improvement should be considered at this time in order to allow no delay as the timing goes forward. Council Vice President Knapp.

Council Vice President Knapp,
Thank you, Madame President. I just wanted to say I share the concerns that you've raised. I know a number of my colleagues have toured the Northwood facility. I had the pleasure of doing it a few weeks ago – at least the pleasure of being with the people. I'm not sure that the tour was all that I hoped it would be. And so I'd like to – and I've talked to Keith about this already – through the course of – as we start the CIP process, to really have a better understanding of what the full project cost that was increased to

$27,000 million has accomplished, what the commitments were made to the community back when this project was undertaken, and where we stand on actually fulfilling those commitments because there appears to be a pretty big disconnect. To that end, I know that the school system, MCPS, has been having regular meetings. I think their most recent was late as last week in which there appears to be real progress, both in getting those expectations closer in alignment with each other. But that's something that the Education Committee is going to look at more closely over the summer.

Council President Praisner,
Thank you. As you indicated, there is not an insignificant amount of money that's already been spent at Northwood. And so the question of what was done and what was planned would be useful over time. Staff change; community members turnover as well, and the parameters and the understandings may be lost in that process. So I guess I will make the motion to approve the Supplemental appropriation. Is there a second? Second, Councilmember Ervin. All in favor? (Show of hands) It is unanimous. Thank you all very much. We now move – and I want to make a comment that I neglected to make. The actions on the Administrative Fees for the Office of the Board of Appeals and the Hearing Examiner were done in District Council Session as District Council. That is a technicality that I neglected to make reference to, and I apologize. Councilmember Berliner.

Councilmember Berliner,
Madame President, could I be recorded as voting in the affirmative with respect to the matters that were just voted on moments ago?

Council President Praisner,
Duly noted.

Councilmember Berliner,
Thank you.

Council President Praisner,
We are scheduled at two o'clock to begin a briefing by Planning Board staff on the Comprehensive Amendments to the Growth Policy. I know I saw Karl; but the question is whether they're ready now, or whether they want us to take the time. Sonya, if you could help me, that would be terrific. Thank you. Oh, okay. Well, then we'll resume at two o'clock. We'll take a fifteen minute break. Thank you. (Break) Good afternoon, ladies and gentlemen. We are back in session in order to receive a briefing on the Comprehensive Growth Policy proposals from our Planning Board. I would welcome Chairman Hanson and Mr. Moritz to the table, and ask you to begin because I anticipate the Councilmembers will be here shortly.

Councilmember Leventhal,
Would it be in order to congratulate the Chairman on his sartorial choice today before he begins?

Council President Praisner,
Whatever you want to do, George. (Laughing)

Royce Hanson,
This is really a push for me.

Councilmember Leventhal,
It takes a real man to wear an ice cream suit. Looks great. (Laughter)

Royce Hanson,
Thank you kindly, I recommend them if you have to wear a suit in the summer.

Councilmember Leventhal,
The problem is you can only wear them for a couple of weeks, but absolutely.

Royce Hanson,
Well, it's worth it.

Council President Praisner,
Thank you for the fashion information, gentlemen. Can we get to the Growth Policy, please? (Laughter) The appropriate lights to be put on.

Royce Hanson
Thank you very much, Madame President. We're going to talk about a different kind of design today. I would like to mention that in addition to Karl, who headed the staff report, that we have other members who chaired the various committees who are here and who can also help us as we respond to questions. I don't know if Kahlid is here yet or not, who worked with the design section; Melissa Banach, John Carter; Mary Dolan; Roselle George; Rick Hawthorne; Rose Krasnow; and, of course, Karl. What we'd like to do – I'm going to spend just a few minutes with sort of an overview of what we attempted to do in this version of the Growth Policy, and then turn it to Karl to go through a discussion of the details. I understand we have about an hour; is that right? So we'll try to get through this in reasonable short order so that there's plenty of time for questions. Well, there won't be plenty of time for questions; but there'll be time for questions.

Council President Praisner
Right. And I do want to lay out for councilmembers that they've received at least one request from me to get – well, they received a request that if they had modifications to the Planning Board's proposal to kind of put them on the table even generically to allow public hearing comment. I also received a memo in response to a request from the Chairman that any specific questions that councilmembers had, they were to get to Mr. Moritz by last Friday so that the answers and responses could be incorporated into the packet for the first committee meeting. I want to make note of the fact that the first committee meeting has actually been modified slightly and is next Wednesday, I believe, and is a joint meeting with the MFP Committee and the PHED Committee in

order to allow those two committees – one of whom will make recommendations on the fee pieces, and the other of which will make recommendations on the other pieces – consistent with policies that have been the cornerstone of the Council's review on growth for a while now. That first meeting is basically another overview and work through so that we can have a broad opportunity for the committees to raise any issues that they may have. And then the separate committee meetings – I don't have the calendar in front of me – but the separate committee meetings will proceed with anticipate of the full Council action. We have a public hearing this evening beginning at eight o'clock. We have another public hearing on the 26th that will, obviously from a standpoint of testimony, be difficult for our staff to be able to turn around from the committee meetings. But we will try to work through what may be raised in either of those public hearings that generate additional questions. I see several lights. I want to know whether those are lights on the process –

Councilmember Floreen,
Yes.

Council President Praisner,
Okay. Councilmember Floreen.

Councilmember Floreen,
Thank you, Madame President. I just wanted to observe at least that I'm pretty much saving my questions for the committee work, which is where I find it helpful to have an exchange amongst us and the staff. So I just want to mention that. I would assume other councilmembers would have a similar approach. Because the issue of submitting questions in advance kind of makes it a little hard for us to have a good exchange amongst ourselves or with the range of staff in the room at the time. So I just wanted to make that observation. I'm preserving my right to ask questions.

Royce Hanson,
We anticipate that there will be a lot of questions as we go along. What we're trying to do is if there were questions in advance that we could respond to – and we're in the process of responding to some now – so that all members of the Council can see the questions that every other member is asking so that that may actually enrich the dialogue as you go along.

Council President Praisner,
Councilmember Leventhal.

Councilmember Leventhal,
Thank you, Madame President. I actually saw your June 8th memo at the end of the day on June 15th.

Council President Praisner,
Oh, okay.

Councilmember Leventhal,
For whatever reason, it did not get to me. So my staff and I are compiling questions, and we'll be happy to provide them to Mr. Moritz.

Council President Praisner,
Good. Great.
Councilmember Leventhal,
We did not have them by last Friday. We may have them by this Friday; we're trying to pull them together.

Council President Praisner,
Okay. Well, the request had come from the Chairman; and I think it was both a workload and a filtering or a funneling process that they were interested in order to combine them because they might be able to be more efficient in the organization of the answers and in responding, and also anticipated it would save some time.

Royce Hanson,
The Board has a long tradition of taking late testimony.

Council President Praisner,
But obviously the sooner folks get questions in, the better and easier it is to respond. But that does not eliminate – there's no cutoff date like a public hearing action closing, and even in that case, we don't abide by it in a rigid sort of way -- but just a facilitation process. And thank you for noting that you were working on questions, Councilmember Leventhal. Councilmember Elrich.

Councilmember Elrich,
Just for the record, I have already submitted a list of questions to increase Karl's workload. So I anticipate all the Council will get the benefit of those answers. And as far as putting things on the table for the public hearing, I kind of thought that I should be informed by the answers to my questions which weren't simply like, "How did you count this?" but "What are the principles and what are the measurement tools?" before I thought about alternatives. I mean I know what I don't like, but that doesn't mean I know what I like. And so I'm not going to put things on until I think I have a better understanding of both where this came from, but also what I might need to know in looking at alternatives and modifications. So they will be coming at some point.

Council President Praisner,
Great. Thank you. I think the only modification that's been requested that I can recollect is the request that I made to have us at least have an option of looking at Impact Tax structure or collection and calculation based on the old model of specific needs by area and calculation by area and funds. In other words, the old way in which we did Impact Taxes when it was only Germantown and East County.

Glenn Orlin,

If I could ask for a clarification – did you mean for that to just be for transportation Impact Tax; or do you want to extend it to schools as well?

Council President Praisner,
Well, I'd like to see what it looks like for transportation. I don't see any reason why it couldn't be done for schools as well, but I want to see what it looks like for transportation first. Okay. I'm sorry, Royce, to have interrupted your train and introduction. But I thought it was important for us to lay out kind of the structure before we begin.

Royce Hanson,
Thank you. Again, let me start first by saying something that I think Karl will reinforce a little bit later; that is, that the Growth Policy has played a unique role in sort of a hierarchy of planning in Montgomery County. Its function is not to set out how much development should occur or to locate development in any general or even in any particular specific sense. That's the job of the General Plan as amended by all of the County Master Plans – both area sector and functional master plans. Historically its function was to provide better staging of growth so that private development would occur -- if not simultaneously, at least in reasonable concurrence with the provision of the public facilities adequate to serve that increment of development. We essentially invented the Adequate Public Facilities Ordinance when we were doing the initial or really the second plan, and the one that guided the development of Germantown. Because there were scattered opportunities for development all over the place, but the facilities were not there for the outlying areas; and we wanted it to have it move in a more orderly way. Growth Policy then followed a few years later as a way of providing guidance for the administration of the Adequate Public Facilities Ordinance. And both of these developed as a major instrument for our use at a time when almost all development occurring in Montgomery County was on raw land -- so that there was no infrastructure there. And to have development occur prematurely or ahead of infrastructure made no sense. The argument we made at the time was that if the developer gets a loan from the bank, the bank is entitled to a return on its investment. If the public is providing a substantial investment in public facilities, it's also entitled to a return on its investment which includes orderly process of development. So I just wanted to make that point initially. Now, one of the things we've tried to do in this Growth Policy is to rethink a few things. One point to make is that this is basically a tool for managing growth and helping us decide what infrastructure to fund and where to fund and, to some degree, how it can be funded. It involves trying to figure out how we can increase the concurrence of development and infrastructure, and how we can pay for it in a way that helps us achieve the kinds of objectives that have been laid out in the General Plan and in the specific master plans. To do that, we've invented over the years various tests for the adequacy of public facilities. And those tests have focused largely on transportation because that was easy to do – well, not easy to do; but it was possible to do. The other tests dealing with water and sewer really related to their presence in categories 1, 2, and 3, and whether or not they were programmed for the period in which development would occur. What we've done in this report is also to recognize that as we move from an era in which almost all development was on new land, we're

moving into an era in which much – if not most – development for the future will be in the form of redevelopment and in-fill in areas that already have the basic infrastructure in place. So we're talking about increments and marginal growth. We're also looking at what does it cost to produce the infrastructure that's necessary to serve these different increments of development – which raises the question immediately of who ought to pay for that incremental increase. So in this report, we're making a slight shift – which I think will be a trend after we get three points in time – of moving toward a Growth Policy that emphasizes sustainability rather than simply whether or not the facilities are adequate in a particular place at a particular time. So fiscal sustainability means development that pays for its marginal costs, so that these marginal improvements in the infrastructure system can keep up with it. This leads us into looking at where development has been occurring; and we've got a lot of data on that -- on the piece of development which has slowed substantially over the years and is now at about .7 of a percent annually at this point outside of Rockville and Gaithersburg. Looking at the fiscal issues leads us into talking about Impact Tax recommendations. And also if we're going to have sustainable development, looking at or setting some criteria for improving the quality of design in the County, because there's a great opportunity to both enhance the capacity of some of the major infrastructure like transportation systems if we design our communities well; and ultimately, to propose the development of a set of outcome indicators that I know Council has been interested in for some time. We think that's quite feasible and would make it possible for us to measure whether or not the kinds of objectives that we've set for ourselves are actually being met – whether they're objectives in terms of the quality of life or in the provision of infrastructure and so on. So we're trying to move Growth Policy toward growing in a way that doesn't compromise our ability to meet the future needs of the County. This means that we're going to not only have to deal with the new development on new land, but the transformation of some of our older centers. And, as you know, we've got a series of master plans and sector plans underway that address this issue. It also means figuring out how to provide better support for the conservation of existing neighborhoods, and particularly to develop a mobility system that shifts people from automobile dependence to other means of transportation – particularly public transportation, walking, and biking. So what we've tried to do here, if you go to – all right, you're already there – is achieve a closer connection between Growth Policy and the Capital Improvements Program. If you approve the direction we're taking here, we will be coming back to you with a much more detailed analysis of the Capital Improvements Program than I understand you have been receiving in recent years that looks at out years and what we really need to do – whether some things need to be moved up in priority. We're recommending Impact Taxes and fees that reflect the marginal cost of infrastructure. There may well be good policy reasons for reducing fees for some things – or maybe reducing them all. But before you do that, you really ought to know what you're financing with a tax expenditure or that you're asking the rest of the taxpayers of the County to pay for. So we've tried to give you a hard estimate of what those costs are and what kinds of fees would be necessary or taxes necessary to cover those costs; and, finally, to create a culture of design excellence and produce more sustainable communities and centers and, as I indicated, develop some indicators. Our next slide is just designed to give you a general overview of where Growth Policy fits

into the operation of the overall planning system. So with that, I will stop and turn to Karl who will get into the real guts of this.

Karl Moritz,

Thank you very much. What I thought I would do is just talk a little bit about how the Growth Policy has worked for just a few minutes; then take you through our recommendations. As Royce pointed out, we've had an Adequate Public Facilities Ordinance for quite a while. And it is in the Subdivision Regulations. It says the Planning Board may not approve a subdivision unless it finds that public facilities are adequate. And the Growth Policy is the resolution by which you give the Planning Board direction in how to find whether or not facilities are adequate. These are the public facilities that the APFO covers. And the Growth Policy traditionally really focused on transportation and schools, as Royce was mentioning. Back in 2003, Policy Area Review was one of the transportation tests that we had. And up until 2003, we had a two-tiered system for measuring the adequacy of transportation on an area wide basis --policy review -- and on an local area basis, local area review. For each policy area, we would set the maximum amount of development that could occur in these policy areas based on the transportation network. And the last time it was in effect, the areas in dark orange were the ones that were in moratorium; and the areas that are pale orange were areas that had very little remaining development left to go. And, of course, yellow are Rockville/Gaithersburg who are not subject to the test. The second tier of the test is the local area review where we test the congestion on nearby intersections. And in 2003, the Council made this more stringent; and it applied to more development projects. Currently, we have a test for the adequacy of school facilities that looks at the cluster as the geography for testing. And I'll give you an example to show you how it works. At the elementary school level, we would add up the enrollment in all of the elementary schools in the cluster five years out, compare it to capacity for all the elementary schools in that cluster, compare the total enrollment to total capacity. At the elementary school level, if enrollment exceeds capacity by 105%, then a School Facilities payment is imposed on new development. If it exceeds 110%, a moratorium is imposed. And currently, we do not have either situation. So a School Facilities payment is not imposed, nor is there a moratorium in effect. These are the current Impact Taxes. They were changed, again, back in 2003. These have been adjusted for the most recent round of inflation -- $5,800 for a single family detached home. Most development in the County pays the general rate. Metro Station areas pay half the rate because they generate on average much less trips. Clarksburg -- because there's much more infrastructure to pay for -- it pays more. Office, $5.30. You may notice Bioscience pays zero and so does hospitals. And I mention that in part because the Planning Board is recommending a change to one of those. Also in 2003 the Council enacted an Impact Tax for schools, and these are the current rates. They are different for the different types of development because student generation is different for the different types of housing. And, of course, just to mention affordable housing. MPDUs are exempt. Other forms of affordable housing are partially exempt. Royce actually talked about some of the growth trends, but I just wanted to mention -- at least reemphasize -- that although we are forecasting that growth rates are going to be below 1% annually in the future, that the total amount of growth that we expect based on the market and our master

plans is over 200,000 more people, over 94,000 more households, and 170,000 more jobs. Development that's gone through the APFO, that's already been approved, is called the "Pipeline of Approved Development." And here's what we have in there right now. I separated out Rockville and Gaithersburg for you. This represents about 8 years of residential development at the current pace and about 20 years of job growth. Because we will be getting into affordable housing in a moment, I wanted to give you some trends in home prices. The current median price of a new, single-family detached home is $881,000. That's' 2006, and that represents about a 14% increase over 2005. The new "attached home," which is what we call townhouses, went up about 4% to $518,000. As I mentioned, no area of the County is in moratorium because the schools are over the capacity. So I wanted to give you a sense, though – and what I failed to mention was that the Growth Policy uses its own definition of capacity of a classroom: 22 students for a kindergarten, 25 for grades one to six, and 22 and a half for other grades. But the school system uses program capacity -- the capacity of the classroom as it's being used. And I thought you should see -- and I believe I showed you this slide back in January -- what areas of the County are over that program capacity. And this is at the elementary school level; it's the pink. And then here's at the middle school level; it's clustered. And then here's at the high school level. The triangles represent pending preliminary plans at the time; this was from January. Another sort of assessment of where we are in terms of congestion is a chart we give to you in your Highway Mobility Report. And the little orange and yellow dots are intersections that are either near their capacity -- which is yellow -- or over capacity, which is red. The blue dots are what were pending plans at the time. So you can clearly make out some of our corridors or transportation corridors. So you gave us a set of tasks in a resolution last December. I've simplified them to four bullets that I'll be going through in the next few minutes. The Planning Board's response was hopefully to answer all of the specific questions that you asked and also talk about some other issues that they would like to raise with you. So those include: strengthening the Growth Policy as a tool for managing growth and providing facilities; incorporating sustainability and design excellence; and then specific APFO and Impact Tax recommendations. The first is the strengthening of the Biennial Growth Policy Review. And here, really, we're talking about not only strengthening the connection with the Growth Policy to the Capital Improvements Program by using it to identify projects that need to be added to the CIP, but also strengthening connection back to the master plans by using this as an opportunity to assess where we are in building out master plans in terms of the private sector side, but also in terms of the public sector side. Additionally, this would be an opportunity to apply principles of sustainability or other measures of growth that we may come up with as part of this Growth Policy. In terms of sustainability and design excellence, the Planning Boarding is talking about taking a look at our overall vision for growth and where we want to be in the future and suggests that as a mechanism for getting there – as a framework for looking at that future, sustainability offers some very specific benefits. And the specific recommendations that I'll flesh out in the next couple of slides -- these show us what are some of the steps that we might take in order to pursue this. First, sustainability is a general concept that each locality must adopt for themselves. And so we would work broadly with the community to look at this issue and identify a definition that works for Montgomery County. Second, look for opportunities to incorporate sustainability into our

current work program; and then develop and apply a set of sustainability indicators. Now in this particular case, the process of developing them -- the broad outreach effort, the discussion about what is important to various parts of the community, and coming up with the indicators that would result – that part is just as important as applying the indicators that would be developed in the future in order to guide our future decision making. In terms of sustainability, we often think of it as focusing on the environment. And the definition that the Chairman talked about is “sustainable development" is that which meets the needs of current populations without compromising the needs of future generations. And that occurs in more than just the environment, but also in terms of the economy and fiscal issues and in terms of social equity and people's well being. In fact this kind of discussion can be expanded or changed to meet the local needs. For example, even the Planning Board’s recommended or suggested sustainability indicators expand that to include adequacy of public facilities. Here’s some examples of definitions of sustainable development; and, again, these can work for some areas – can be a guide as we develop our own. Now the General Plan most recently refined in 1993 with its goals and objectives -- as we talk about in the report, a lot of those goals and objectives did not take into account our principles of sustainability. And we go through those and talk about, Well, how would those change? How might they change if we decided to reflect sustainability? And, finally, here are some potential indicators that we could use to track over time how well we’re doing in meeting our goals. The second issue that I want to talk about in terms of these two pieces is design excellence. And the particular recommendations that are in the report are primarily how they affect the Growth Policy are looking for opportunities as we assess developer-funded improvements for design excellence – particularly, are they pedestrian friendly for example. Other recommendations that the Board is suggesting is a design summit of County agencies that produce public projects or review private development in order to start coming to some sort of consensus on what does “design excellence” mean? What would it mean to have a culture of excellence and what steps would be needed to pursue it? Down at the Planning Board, we're talking about coming up with a protocol so that the planning staff understands and has it laid out for everyone to understand what’s expected when they bring projects to the Planning Board in terms of design. And here are some other design guidelines, either in or alongside master plans. A revision of the Zoning Ordinance – that is in our Work Program -- is an opportunity to look for those kinds of opportunities. And then, specifically, LEED-ND is another option. When we talk about design excellence, we are talking about the public realm – not necessary the design of buildings or the architecture itself -- but what happens between buildings, the realm that all of us inhabit when we’re not at work or with our families but out with the public. And these two pictures show sort of two ways in which the public realm is not only necessarily the street itself owned by the public, but leads into areas that are on private land – that are enjoyed by the public as you walk down the street, etc. This next slide and the one that follows have about the same density. These are not Montgomery County pictures. They are produced by the American Planning Association. This first one has the same density as this one; and yet you have a completely different feel. You interact with this in a completely different way. What I think also is interesting about this is the previous slide has five lanes of traffic, whereas the next slide has six. And so it isn't necessarily a measure of how many lanes of traffic that you have, but other design

elements. In terms of public design, we have a traditional kind of viewpoint -- for example, of parking garages. And yet – there's the Glenmont and Silver Spring. (Laughter) Well, we couldn't help it. And yet, there are alternative ways to accommodate public parking.

Royce Hanson,
These are also parking garages.

Karl Moritz,
Yes. These were not built by the public; these are in Clarendon. And the top two stories of this building is public parking serving that neighborhood. So attributes of good deign that are distinguished from the quality of architecture necessarily, and these are sort of principles that a wide variety of architectural styles can still accommodate. One last – or actually two slides I want to mention. One is how each site is unique. And these are two similar sites: one is the entrance to City Place; the other is the entrance to the Barnes and Noble in Bethesda. And they both have a corner where they're trying to engage the public, welcome people to an entrance; and yet they work in different ways. Finally, the experience of Millennium Park in Chicago where the original design idea was to just cover the railway station and make a park -- perhaps some parking to help pay for the park. And yet they challenged themselves to do something more. Finally, with the nuts and bolts parts of the Growth Policy, the APFO and infrastructure financing. The summary here is a recommendation to reinstate a policy area review test for schools to lower the threshold when the school facility's payment kicks in; for Impact Tax to set it equal to the cost of infrastructure needed to support the increments of growth, the marginal costs; and then with the Recordation Tax, set that to capture students generated by turnover. For Policy Area Review, the Board decided -- and staff recommended -- that we do need an area wide test – that we don't capture what's going on with the transportation network sufficiently just by looking at nearby intersections. And certainly as we do master plans, we're doing that kind of analysis. And Policy Area Review would be also the basis for how we do traffic studies for master plans. With local area review, we are recommending retaining the basic tests; and there's some – but some changes that we are recommending. In deciding what kind of tests Policy Area Review should be, we looked at a variety of characteristics. And those included: Is it measuring things that are important to our residents and the people who live and work here? Is the thing that we're measuring relevant? Does it actually measure what we're trying to get at? Is it understandable or coherent? When we explain it, do people grasp what we are saying? And we have not always achieved that in the past. Reliability -- if we keep doing this over the future years, will we continue to get good results? And then, Is the data available now and can we forecast it in the future? How we would apply it is each year at the beginning of the fiscal year – well, in the spring -- the Planning Board would recommend and the Council would adopt a finding of each policy area being either adequate or inadequate based on its transit and roadway mobility. If it's adequate, that area would be open to development approvals for the next fiscal year; and if not, development would be required to make it – either way, until it became adequate or make additional contributions toward adequacy. I'm only going to mention that this is

how the traffic model that's used to measure automobile traffic – these are all the links that it looks at. So it's not simply a few roads in a few policy areas, but it's the region as whole. Okay. This is how we suggest measuring the level of service for transit in Montgomery County. And so it's a system of letter grades, depending on how well the transit service is in that area. How we measure it is if the transit speed is better or worse than your trip by automobile. If it's better, we get an "A" in that policy area; if it's worse, there are varying degrees of worse. If the trip by transit is 75% of the speed by auto, you get a "B." If it's between 60% and 75%, it's a "C" and so forth. Here are the scores for the various policy areas. So most of the policy areas in the County get a "C," with a few getting a "D," and Damascus getting an "E." In terms of roadway level of service, auto congestion, we suggest measuring it by how quickly we travel during congested periods – during the peak period -- compared to how quickly you can travel when there's a free flow. So if you can go at least 85% of free flow speed during a congested period -- the peak hour -- that's considered an "A." If your travel is between 70% and 85%, that's a "B" and so forth. And here -- excuse me. Before I get there, I wanted to illustrate what that means exactly. So this is an example that's in the book, and I am metaphorically traveling south -- from the bottom up to the top – from Strathmore up to the Woodmont Country Club, a distance of 2.7 miles. At 40 miles an hour, free flow speed, that takes about four minutes. I'm just -- sorry -- picking a roadway distance that people might know. Then at level of service "C," you'd only be able to get 55% of that distance or about 1.5 miles going an average of 22 miles an hour. For the same time period, four minutes, at level service "D" you could get about 1.1 miles. Now, these are the scores for the various policy areas: three get a level of service "B," three get a level of service "C," and the rest are "D." Now these are in order of how well they do. So at the bottom you have Potomac, North Bethesda, and Fairland/White Oak. Now the concept that the Growth Policy has had really since its inception in the 80s was that we would allow additional roadway congestion – which we unfortunately, are calling "arterial congestion" just to be less transparent – we would allow more roadway congestion if there is better transit service available. So this chart shows the tradeoff that we're proposing. If the transit level of service is "B," we would allow down to a level of service "E" on the roadways. If the level of service is "C," we would allow down to a "D," etc. So this is how everything works out. And I'll take Aspen Hill as an example; it has a relative transit mobility score of "C." That's what the transit level of service is in Aspen Hill. That would allow a roadway level of service of "D," and that's what it has. So it would be considered adequate. If we moved down to Germantown East, it has a relative transit mobility score of "D." That implies that we would allow roadway congestion to get as bad as "C"; but, in fact, it's "D." So that's considered inadequate. If we go down to, say, the Rural Area West, it has a transit level service of "C"; and it could go as bad as "D," but in fact it's "B." So, again, it's adequate. In areas that are inadequate -- and in this case we found that Germantown East is -- one of the options that we wanted to pursue was an increased emphasis on non-auto improvements. Individually, each of these things don't do a whole lot. The objective here is creating an environment that is pedestrian friendly, And there's a point at which you make all these investments, and you have a pedestrian-friendly environment. You do need to start somewhere, and we have started; but each increment does contribute. But we're not, I guess, claiming that there is a particular benefit to, for example, one bus shelter. Of course, in the past we've

allowed roadway improvements when an area was inadequate; and this Policy Area Review allows that as well. These are the lane miles that you could build in order to get a credit of a hundred trips. Recently I was asked, “Well, what are the options for improving roadways in Germantown East?" since that’s the one area that we have found to be inadequate; and here are some of the options that there are. And then, of course, also there’s the transit and non-auto amenities that I talked about. In terms of local area review, we are recommending retaining the more stringent standards that you adopted in 2003. Some of the other changes are small, but one I want to mention in particular is that we would be asking when an intersection is inadequate that each one of the traffic studies -- each developer -- be required to show how trip mitigation might be accomplished so that that’s the first option that’s considered. And they would have to explain why that was not considered. For the School Facilities Test, what we are recommending is based on two changes that the Board adopted: one is the finding that a moratorium has limited effectiveness in terms of the school test because so much change in enrollment is not due to new development, but that a moratorium still has utility when things have gotten really, really bad. And then also a discussion of moving from Growth Policy capacity to program capacity; in part because the gulf between those two has gotten wider in the past. The Planning Board’s recommendation is to lower the threshold for the School Facilities Payment; it’s 110% of program capacity. That is much lower than the current test, which is 105% of Growth Policy capacity; and I’ll show you what areas would be affected in a moment. Then, increase the School Facilities Payment to reflect the fact that it cost this much to build schools for each of these student levels. So the Board would continue to impose a moratorium if enrollment exceeds 135% of program capacity. That is a similar result as what we get today with the current moratorium test, and there would be no more borrowing from one cluster to another at any level. Currently it’s just at the high school level. Okay. What would happen if the Board’s test is imposed at the high school level? One area is inadequate, Wootton; it would be subject to the School Facilities Test – payment, excuse me. A single-family detached home generates .13 high school students; you multiply that times the cost per student. That would be the cost for a School Facilities Payment for a single-family attached home, or $6,200. For middle schools, one area is inadequate; and the School Facilities Payment for that would be $6,100. And that’s the amount of the cost per student times the number of middle school students generated by that housing type. And then, finally, here are the areas that are over 110% of program capacity; and they would be charged $10,000 per home – considerably less, of course, for townhouses and multi-family units. In terms of Impact Taxes, the Board’s themes are that the growth should pay for the cost of infrastructure needs to support it. As the Chairman mentioned, there is a long investment in infrastructure that future development is taking advantage of – infrastructure that they did not contribute to. The Planning Board’s suggesting that new development’s responsibility is to pay for the additional increment. And I will go on to the next. Here’s the School Impact Tax recommendations – again, these reflect the marginal cost of school infrastructure for these types of housing. Again, we talked about, “Well, what are the sources of school enrollment change?” Much has been made that it happens in existing housing units as well, although perhaps eight times the number of existing home sales as new. New homes generate maybe five times as many students per unit as the turnover of existing. So the Planning Board tried

to craft Impact Tax and Recordation Tax recommendations that would reflect that. And doing so means that the responsibility of existing housing for new infrastructure comes to a Recordation Tax of $11,021 up from the $690 that is currently charged. Of that, Maryland jurisdictions -- and agreeing that there are many charges that occur at home sale -- but the Recordation Tax around the state, thirteen jurisdictions have higher rates than the County does now. These are the recommended transportation Impact Tax rates. You may remember the single-family detached currently is $5,800; and that's $8,300. On the office side, current is $5+; so it's about double. The Planning Board is recommending that the Bioscience not be given a zero Impact Tax rate any longer; that it no longer needs that stimulus. And also, I think, questioning whether or not Impact Tax breaks are an effective stimulus. The Board would not change the rate for places of worship, and I'm sorry that's asterisked. There's no reason for that. And then would not change hospitals either from the current zero. We talked a lot about both management and housing affordability during the Board's discussions over the course of the study, and there are some documents in our interim reports that we provided to you; but not as much in the final report. So we're going to spend the last five minutes on that. Economics 101 tells us that when land supply is constrained, that will result in an increase in the cost of housing; but a lot of things complicate that statement. Among those is the fact that we're in a regional economy, and so we're really talking about "Well, what is the regional supply of housing and land for housing, and what is the regional demand for that housing?" And that's what really sets the market price for housing. Local government's ability to change the regional market price – the regional supply and demand – is somewhat limited because we're just one actor. In addition, there are different things that a local government can do that have different effects on the supply of land for housing. And I would argue that master plans and zoning are a greater constraint on the supply of land than, say, something that's oriented towards timing – such as the Adequate Public Facilities Ordinance. You know back in 2003, we did do an assessment on the effect of moratoriums on how much development had occurred. And we found that when the moratorium was not in place, development did occur; and when the moratorium was lifted, development started right up again. And I think it became almost a famous number that overall -- over the growth of the Growth Policy history -- we only stopped eight hundred and some units from being built. If we accept those findings, then we must, I guess, also find that we are not affecting the supply of housing in a material way and, therefore, increasing the cost. Impact Taxes. We spent a lot of time talking, and had not only research but economists come and talk to us about the effect of Impact Taxes on affordable housing; and over the past years, there's been sort of a comment that, "Well, if we raise Impact Taxes, they will immediately be passed on to the homebuyer." Part of the job this year was to say, "Well, no. It's more complicated than that." And it is really a cost to the builder, and what happens after that depends. Economists say over the long time, developers would compensate for that increased cost by offering less for the land that they buy. They may also delay their home building until the home price rises to accommodate the Impact Tax increase; and I'll explain in a minute why that's not the same as passing it on to the home buyer. One thing that our economist that we brought in mentioned was that there was some finding that home prices can increase in areas with Impact Taxes. If you spend those Impact Taxes to improve your community, it becomes more desirable. To

give you a sense of just how big are these Impact Taxes, they look like enormous numbers. And they are if you say, “Well, it’s double what it was before.” But if you compare it to the cost of a new home, it’s a little bit of a different story. Back in 2003 when we imposed Impact Taxes at the new rates, it was about 1.2% of the median cost of a new, single-family attached home and about .9% of the cost of a new detached home. And that’s gone down since then as home prices have risen. The Planning Board’s recommendations would increase that just a bit ahead of what was the case back in 2003 to 1.3% of the price for townhouses and 1% for single family. For School Impact Taxes it’s different because the changes are greater, and it would increase by 1.5 percentage points. You can see that over time, the ratio of the Impact Tax to the cost of a new home has been going down; the Board would bump it up by 1.5 points. So another way of looking at it is – because I mentioned earlier one accommodation strategy for a builder would be to wait until home prices had increased to cover the cost of the Impact Tax. So how long would a developer – a builder have to wait? Well, in the last year during 2006, the median price of a new, single-family detached home rose by $116,000. You may remember that the total Impact Tax that the Board’s recommending is about $31,000. So you would take about four months for the home prices, at that rate, to increase enough to offset the Impact Tax. And I didn’t mention it before, but the Board is recommending that the rates be phased over a 12-month period. And the last point on my last slide is that the Board is also addressing affordable housing in other ways than the Growth Policy this year, along with you and the community. First, our sustainability recommendations explicitly include affordable housing as one of the measures that we would look at. But also the Work Program that you gave us this year looks at preserving affordable housing, revisiting the housing element of the General Plan, and other affordable housing issues. And that summarizes – the last two slides are just a summary of what we’ve talked about.

Council President Praisner,
Great. Good. I’ve been asked by a couple of colleagues, and I want to acknowledge that Councilmember Knapp had to leave for a doctor’s appointment. I’ve been asked by colleagues as to what we might do now, so to speak, after the presentation; and I would suggest if there are additional or specific questions the councilmembers may have based on the presentation, especially those for additional information -- this basically was a briefing in order to set the context so that we all had the same information for this evening’s public hearing which begins at eight and as a preliminary to the worksessions. If councilmembers do have specific requests for information, now would be a good time as well to add them to the process. But seeing none, or if there aren’t any, we would resume obviously the discussion this evening with the public hearing. Councilmember Floreen.

Councilmember Floreen,
Thank you. I know you’ve had a series of public forums and so forth -- would bring in folks from, I guess, around the country to talk about the policy issues and different approaches. And I did ask that you ask a question of them. I don't know if you got my request or if you asked my question. But I was interested in hearing from those experts as to whether there is any place else in the country that has this combination of

controls. I know that there are various places that have some measure; but I was curious as to whether there's any jurisdiction that has the collection of taxes, transportation tests, and school adequacy tests along the lines of what you're presenting to us here. So I don't know if you asked that question, but if you could let us know at some point.

Karl Moritz,
We did, and we will let you know.
Councilmember Floreen,
Okay. My other thing – and it's a policy question – that we'll discuss later, I guess. But as you know, we've been working on the Road Code. And I think we're done, basically; right, Mr. Orlin? Yes, we think we're done.

Council President Praisner,
We'll see if we're really, really done on Tuesday when we discuss it.

Councilmember Floreen,
Well, nothing's easy; I certainly accept that. But I ask because your transportation test here priorities mobility, and our Road Code work does not. It prioritizes, to a large degree, attention to the long-neglected, in my book, pedestrian and bicyclists. And so I would ask you how we reconcile this effort; because when you talk about these tests that have to do with relative speed by which you can get up Rockville Pike or wherever, how do we reconcile that with the policy desire that goes more into your design section really and sustainability section really on community livability? So if you can take that up at some point in our conversation, I'm very concerned about that because it certainly was an issue that came up in our committee conversation. "Oh, my gosh, this could have the potential to slow traffic in certain places"; and if that is the case, is that contrary to a test that prioritizes speed in the community analysis?

Royce Hanson,
I think that the test that we're proposing doesn't necessarily prioritize speed. It looks at the relative time that it takes someone to move on the roadway or to move by public transportation. I don't think there is a conflict between what you're trying to do in the Road Code and what we're recommending here -- either in the transportation tests or in the design elements; but we can take a closer look at that.

Councilmember Floreen,
I ask that you take a look at it. I was just reading, apparently in Massachusetts they threw out their level of service standards because it was inconsistent with the complete streets effort that apparently they've remarkably adopted. I come from Massachusetts, and it's news to me that they're thinking this way; but apparently the design control issues have caused some revisitation of the standard traffic engineering standards -- which are what we've been trying to move away from in any event. But I'd ask that you look at that; because I have a little concern about whether we're prioritizing numbers over community.

Royce Hanson,
Well, we'll be prepared to discuss that.

Council President Praisner,
Councilmember Elrich.

Councilmember Elrich,
Looking at the mobility test – I wouldn't worry about anybody thinking this prioritizes speed since basically car speed collapsed to 25% of the speed in the area. And as long as buses were moving at 75% of that 25%, things were fine. So basically if your car speed drops to 10 miles an hour, buses are going 7.5 miles an hour; this test seems to be working. So I don't think this is like a speed test by any stretch of the imagination. I would like – and it's not in here – a more detailed explanation of how local area transportation review works. What's counted when a project comes up for approval? There was a lot of discussion on Rockville Pike for example over which projects were counted in the background for other projects. And I've been involved in another study where a major project wasn't counted; and after some debate, we discovered that in fact the traffic engineers were following the County policy. But the County policy didn't count cars that everybody knew were going to be on the road; they just came from far enough away that their impacts weren't counted. And I think we need to be clear about what's counted in the local area transportation review. I'm curious about how we deal with situations as I described to you, Karl, where it's impossible to fail the critical lane volume because cars can't even get through the intersections. You can't get above 1,600 cars going through an intersection because the cars can't move at rush hour. I'd also like to see these numbers – your assessment done on what works and what doesn't – for the PM rush hour when everybody's on the road. Because to test road capacity and say things are flowing smoothly at six o'clock in the morning is all fine and well; but when everybody in the community is out doing the things that are part of daily life, I think we need a real world test that says, "What's it like at 4:00? 5:00? and 6:00 in the afternoon?" And I think it's not going pass the laugh test of the community if we say that we tested this at six o'clock in the morning, and there's plenty of room on the roads. There's plenty of room on the roads because most of us are trying to sleep at six o'clock in the morning. And I guess I'd like the underlying basis for the mobility review – where the mobility review comes from, because everything in here seems to tell me this is a local concoction. And it's not based on – I mean, what makes something an "A," "B," "C," or "D"? Who decided that? Who decided that something was excellent, fair, or poor? Is that something you can go to a manual or something that's been tested someplace, or is that the assessment of whoever put together the various proposals? I think it's important to know where these descriptions originated from. And I'm very interested in how you do policy area – the larger analysis of travel times. I was just playing with something and I said, "If I drove my car at 10 miles an hour from my door to my job, it's an hour trip." And if I was using public transportation, and I was lucky enough to not need to transfer – which I think is, you know, many trips require one or more transfers; and if I was lucky enough to be able to walk to a bus stop in four

minutes and arrive there exactly when the bus arrived, and there was no waiting time; and then I got off my bus and walked to my job in four minutes – it's about a quarter mile or so walk; and if my 10-mile-an-hour car drive turned into a 7.5-mile-an-hour bus ride -- because buses don't travel on roads as fast as cars do because they're stopping frequently – that alone adds up to an hour and twenty minutes. And I just find it hard to believe that things are so well timed in this County that people walk four minutes and the bus pulls up, picks them up, they go to a station, they transfer, they walk off a bus and get on another bus and go somewhere. Because that's not my experience. I've asked people who are taking multiple trips like this to report their experience; and waiting, and inconsistency, and all those other things are part of their experience. And then, lastly, how do you weigh in the experience of the transit trip itself? When you're comparing strictly times, part of what you're comparing is standing out there in 90 degree heat or standing out their in the rain or the snow or any number of other conditions as if the car ride was the exact equivalent in all aspects of a transit ride; and the only difference is time that says people will simply say, "Oh, for a couple of minutes I'll take transit instead of using my car." But I don't know if I would stand in the rain for a couple of minutes or the snow for a couple of minutes or do anything of these other things for a couple of minutes – let alone fifteen minutes. And so I don't think this is something where you can draw an exact equivalency and say, "Here's the time of a car ride, and here's the time of a bus ride." People make decisions not just based on time, but on the quality of the trip. Just a few questions, and then you have my other list.

Council President Praisner,
Councilmember Berliner.

Councilmember Berliner,
I have three questions for you that I'd appreciate your response to. Dr. Hanson, I appreciated your opening in which you alluded to what you felt to be a fundamental change in the County since the Adequate Public Facilities Ordinance was first adopted – that we went from a, if you will, "a greenfield environment" to an "in-fill redevelopment environment." And that you believe that that is a fundamental transformation of our community as it relates to the Adequate Public Facilities Ordinance. What I'd appreciate in this moment you giving expression to is, "How does that change manifest itself in your recommendations? What are you recommending to us now that you would not have been recommending but for this fundamental change?"

Royce Hanson,
You want an answer now?

Councilmember Berliner,
I would.

Royce Hanson,
I think there's at least one major thing that occurred. My guess is if we were still primarily developing on raw land, we would probably be much more inclined to support what would in effect be moratoria for areas that do not have even the basic

infrastructure in place for them to develop. And I think in effect that's what was done in some of the early aspects of Growth Policy; because if an area was not served or was not programmed to be served within the time frame that the development would occur, it was hard to justify a development going ahead. Now there were cases, I know, in Germantown in which road clubs were established where the road infrastructure was not yet available; and developers pooled resources in order to build segments of roadway. Nancy, as a former member of the Board, may have some recollection of some of these measures.

Council President Praisner,
We're still dealing with the problems of them – of road codes that didn't work.

Royce Hanson,
Yeah. And very often they didn't work; or people weren't ready in time, and they didn't have enough money and so on.

Council President Praisner,
Didn't all develop at the time they built the road.

Royce Hanson,
So I think one of the things that we're looking at here is that now if you look at the places that have a substantial amount of excess capacity, let's say for roads, they're basically where we don't want development to occur. So if we place in moratorium those areas around Metro stations, for example, which have the core elements of infrastructure in place, then where development will occur is where it can. And where it can, is where there is excess capacity and where we don't want it; because over time, it becomes very inefficient. If it develops there, it will generate demand for additional services and facilities that will have an impact on the tax rates and so on. So I think a major difference here is to say – one of the things that we've been doing historically is we have been distributing the cost of infrastructure that's needed to serve the new increment of development over the entire tax base and all taxpayers in the County. Now, the advantage of that politically is that the bite is relatively small on each individual taxpayer; so it's distributive economics. But if the base taxpayers have already paid for all of that infrastructure, that now serves as the base for new development. So what we're saying here, which is a major change, is that the Transportation Tax, Impact Tax, and the School Impact Tax should be geared to the marginal cost of that new growth and using the tax system as a way of also providing a substantial amount of revenue that can be used to keep the infrastructure up-to-date. What I think we want to avoid is a situation in which we say you can't build things that we would like to see built, and we don't' have the money to provide the infrastructure to do the kind of redevelopment and in-fill we would really like to see.

Council President Praisner,
Roy, I asked Roger if I could chime in; and here's my fundamental problem. I think your logic works in the rural areas of the County where you may be concerned about development occurring, and it may be accurate as it relates to your Metro areas. But

we've adjusted for that by looking, to some extent, at congestion levels and varying those congestion levels. I think your logic falls apart in that "rest of the County" argument – that middle area, and I don't mean geographically middle, but in that suburban area of the County. Not the rural, and not your central urban area, but I think it falls apart or is harder to hang or embrace when it comes to your suburban areas; and I'll tell you why. Because when you look at where the red dots and the congestion are and the problems were before, they were mostly in that suburban area – not in the rural areas of the County and not in our central business districts where we have poured infrastructure and where we have assumed or also recognized congestion. And so, therefore, the issue of sustainability is something that I would embrace; but you've got to be at a place where you feel comfortable before you can sustain it. So you don't maintain a weight if you're still trying to have some weight reduction. Once you reach the level that you want to be at, then it is an issue of sustainability. And I think when we stopped the policy area review discussion in 2003, as Karl's charts show, we had areas of the County that had congestion levels that were not adequate or acceptable from the measures that we were using. And now we're talking about in-fill and redevelopment as if the infrastructure is in place. And I would argue that for some, if not all, but for many of the suburban areas of the County, so to speak, infrastructure is not adequate at this point. So it almost is a broad brush looking at the three geographic types of area and making some assumptions that I think we have problems with or continue to have problems with. So I think we continue to have an issue about capacity and sustainability when we talk about the current conditions for some of those areas; and I hope when we get to committee, we can have a further conversation about that. Councilmember Berliner.

Councilmember Berliner,
Dr. Hanson, let me ask my other questions as opposed to having you respond to the Council President; because I know you will have plenty of opportunities to do so. I was among those who, in campaigning for this office, felt it had been a mistake back in 2003 to eliminate the Transportation Area Policy Review. So I am grateful for your recommendation that you, too, believe that that Policy Area Transportation Review served an important function. And I also recognize, as I know many did, that it was a flawed measurement. It was a difficult tool to use. So I appreciate why you would have felt that rather than going back to that which was flawed, that you would in fact develop a new one. I will share with you my concern at first blush with respect to the grading system, and just say to you that if my son brought this level of "D's" and I suggested to him that this was adequate, it would not be a pretty conversation -- or if he suggested that, "It's adequate, Dad, that I have seven 'D's' here." So talk to me as to how you believe that, if you will, a "D" is adequate – particularly in the context as I appreciate it that the cost of inadequate is mitigation as opposed to moratorium. So in that context, tell me why you feel that this particular measurement achieves the result that is most appropriate; and I would appreciate that conversation now.

Royce Hanson,
I'll make some comments on it, and Rick or somebody here may be able to help with some of the more detailed analysis. We're really talking here about relative experience

of the traveler between road and transit movement. In some ways, if our long-term objective is to provide greater opportunity for people to use public transportation or to walk or use other means of transportation, creating a system in which traffic flows freely is frankly not likely to help us achieve that objective. I think that –

Councilmember Berliner,
Is this a version of we should consciously choke ourselves so that we then promote the -- I want it articulated. Is that your view?

Royce Hanson,
I think that I wouldn't go that far.

Councilmember Berliner,
How far would you go? It seems like you were going pretty close.

Royce Hanson,
I would say that in a metropolitan area of five million people and growing, that if Montgomery County did not grow one additional person, traffic congestion in many places would increase. Now, what we've proposed is a two-step process: one, that looks at the relative experience by road and transit for people in each policy area; and a second test -- keep in mind that this is not one test; it's a two-step test. The second test really addresses the intersection congestion issue. And there, under local area transportation review, if the local transportation situation -- either a link or an intersection within a reasonable distance of the project is operating inadequately – will operate inadequately if the development proceeds – then mitigation must occur under that test, just as it does now. So that may mean intersection improvements. It may mean lane improvements. It's also conceivable as Karl was suggesting – not only conceivable, but we ought to do it – is to have improvements to public transportation. You and Marc and I were talking the other day. In particular developments, maybe buying a bus is a more appropriate strategy than trying to change the configuration of an intersection. There are other operational measures that could be used. For instance one of the slides that Karl showed you is a change in the roadway configuration that produced more lanes but better environment. So there are things that we can do in that regard. So we're not proposing to just let people deal with it. We are proposing a means by which we can identify changes that need to be made and can begin to both make those changes through the public process and also provide some funding through the development process that can help finance some of the changes that need to be made. I don't know – Karl or Rick?

Councilmember Berliner,
I had one final question if I could, and it really relates to a criticism of the report that I have heard with respect to an issue that I am fully supportive of – and that's the question of sustainability – but a sense that sustainability, that the concept was not linked sufficiently with outcome measures and how we would achieve that. I feel like your presentation today in some ways was more illustrative, and I would ask us in the

future to have more specific conversation as to how this concept in fact gets legs and doesn't exist in a vacuum and how we know what that means.

Royce Hanson,
If -- assuming of the Council supports this approach, what we would follow-up with is a means of selecting a specific set of indicators -- vetting this through a public participation process and discussions with you all -- to come up with a series of indicators that measure the things that we think are important to measure in terms of sustainability and quality of life. A number of other communities around the country have begun to do this; and it, I think, is very helpful in that it helps us get smarter. If something that we're proposing either isn't working or isn't working the way we thought it would, it's really important to know that as soon as we can rather than to go on for twenty years. I think I've mentioned a book of essays I once edited about urban growth policy in which one of my authors ended his essay by saying, "What we're doing isn't working, but we're doing it better than we ever have." We don't want to be –

Council President Praisner,
That's called sustainability, I think.

Royce Hanson,
We don't want to be in that situation; and if it isn't working, we need to know so that we can fix it.

Councilmember Berliner,
I thank the Council President for –

Council President Praisner,
Last two comments, Councilmember Andrews, and then Councilmember Elrich.

Councilmember Andrews,
Thank you. I think what the public is interested in is primarily, "How do we manage growth so that conditions on the ground bet better?" Does their local commute improve, or does it remain at an unacceptable level? And while the interstates are a whole other story, and we have limited impact on what we can do about traffic on the Beltway or 270, we can do a lot about local roads. And we did something about Great Seneca Highway that made a big difference at very modest cost. It's the best example I can think of where a relatively inexpensive road improvement cleared out a road so it's free flowing pretty much during rush hour and certainly the rest of the time. But it flows much, much better than it used to. Traffic used to back up a mile sometimes at the intersection. We added a through lane, lengthened the left-turn lane; we added a right-turn lane and managed the flow better with a traffic signal from Sam Eig Highway to Great Seneca. What will this report do? What will your recommendations do to improve the likelihood that when we add road capacity on local roads and non-interstates – whether we do it or we do it with the State – that we'll actually see an improvement in the level of congestion versus just keeping up with the traffic added by development? I think that the public makes a big distinction between the two. And the public clearly

does benefit if there are reductions in congestion levels that they see on a daily basis. But what people don't want is for expanded transportation capacity – especially expanded road capacity – to fill up with traffic that results from additional development. That's not what they want to see as the result. So how these recommendations increase the likelihood that when we make roadway improvements, for example, that we actually have a long-term increase in the ability to move through the intersection.

Royce Hanson,
Well, it will take not only the kinds of recommendations that are made here, but it will take some follow through – particularly, and this is one of the reasons that we placed a heavy emphasis in this report for the first time on the quality of design. And that deals not only with the design of the roadways, but it also deals with the design of major centers. Much of the congestion that occurs on our roadways are at either major centers or outlying centers. If you look at Georgia Avenue for instance – the Layhill/Georgia/Randolph intersection is a major congestion point. And you do find severe links -- for instance all along Rockville Pike, which I'm sure you're familiar with -- in which both the kind of development that occurs along the roadway and the frequency of curb cuts has a major effect on the operational characteristics of those kinds of roads. But I think we find a number of instances – and we've got some in this metropolitan area and, indeed, I think, some in the County – where congestion levels have declined as a result of really well-designed areas. Everybody points to the Route 50 Corridor in Arlington – which at one time was heavily congested and actually has improved, although density along it has greatly increased over this period of time. So I don't think there's any magic to this that says, "If you adopt these recommendations, everything's going to get better right away." I think we have to look at ten/twenty years, which is a cycle of change in an urban fabric, to bring this about. And what we're trying to do is get it started.

Councilmember Andrews,
One other question; that is, what was the basis for using 135% as the trigger for the school's test for going to a moratorium rather than a lower number? Just a rough calculation – you wouldn't reach 135% of capacity in a school until you were in a situation where you had 30 students in a class that was supposed to be 22. So if every class averaged 23 and you're at 30, you're still under 135% there. That's a pretty big overage on an average basis for an entire school. So what's the thinking on 135% as the trigger?

Royce Hanson,
Want to go on that one, Karl?

Karl Moritz,
Well, a couple of things. The 135 corresponds pretty closely to the current test for a moratorium. Well, the Planning Board's overall objective was to say that moratoriums would go into place when it was really bad. So then the question was, "What's really

bad?" Given that we're dropping the threshold for adequacy from the School Facilities Payment to what is considerably tighter than it is now – about 110% of program capacity – the Board looked at a number of options and said, Well a quarter more is a reasonable threshold for imposing what is a somewhat, I guess, drastic measure of the moratorium given the utility that the moratorium generally provides in terms of stopping enrollment growth. The one growth accommodation or capacity accommodation strategy, of course, is the portables. And this growth capacity number does not take portables into account; so there's that. But those are the numbers. I would say that of the many numbers the Board is recommending to you, the 135 is one of the fewer ones that a lot of data point to.

Councilmember Berliner,
All right. Thank you.

Council President Praisner,
Last question. Councilmember Elrich.

Councilmember Elrich,
Couple things – or a few points. Couple of questions. Well that's why I piggyback on Phil's point. The difference between schools and the transportation tests to me is sort of fundamental. The transportation test is quality of life. The school objective of reducing class size was educating children in the best environment. And my problem with the 135% is, you can collect all the money you want as compensation for overcrowding classes; but all that money doesn't offset the damage done to the kids' education. If we really believe that reduced class size is a laudable and worthy objective – not because parents like to think of smaller classes, but because kids learn better – than the payment of money doesn't offset the damage. And so I think the test is too high. One-third higher means that elementary classrooms can go from 22 to 29, and kindergartens can go from 15 to 20. And that's just too much. You lose the ability to achieve what it is you set out to achieve. So I would tend to agree that that's too much. I want to talk about some of the other stuff that you've – Just briefly as questions or if you can to get them to comment on later. We've got to talk about what "urban" is versus "suburban." Just because you've got a couple of nodes in the County that have high-density development doesn't mean the County is urban. And to talk about urban standards seems to me to be a mistake. Most people are going to live in what are still considered suburbs, even though you've got a couple of urban nodes in the County. And I think we need to not confuse the changes in the nodes with changes in the County as a whole. I want to understand why in your PAMR tool – it seems to me it doesn't give you the ability to do what you want to do, which is focus development where you want to focus development, because nothing fails. If cars could go – if the average speed on an arterial was either 40 or 35 miles an hour, cars can go 16 miles an hour, and they can drop as low as 10 miles an hour -- 40% versus 25%. And buses drop from 9.6 to 7.5; and all that's considered adequate. So that bus transportation can actually get worse, because what's considered acceptable on the bus is tied to what's acceptable in a car. How does any of this let us put – say, for example, jobs in Germantown? If it leaves the whole County open, and everything is okay everywhere – my first question is, "Why

should we build any more roads?" because it seems to me we could save a lot of money if everything is "fine." But if things aren't fine, how do we use this to direct jobs where we want the jobs? And how do we keep jobs and development away from areas where we don't want it to occur? And I don't see where your tool lets us do that. Again, you focus on the urban cores; but you're not going to put so much density in the urban cores it's going to change the population balance in the County. So people have to leave the urban cores and go to work. All these jobs are stretched out along the I-270 Corridor, and we're talking about a Life Science's Center over in the Hillendale area. Those people are going to be driving there out of Silver Spring and out of Wheaton and places like that. Just because they're on a Metro Center doesn't mean they're going to use Metro. We know why this Metro system was built; and it wasn't to do intra County mobility. It was meant to move a workforce which left D.C. back into D.C. for jobs, so they could go home at night in the suburbs. And so unless you live – if you're in Wheaton or Silver Spring, unless you've got a job south on the Red Line in D.C., you're not using the Red Line. So the fact that you build on a Metro Station doesn't mean that you're either going to work in Silver Spring or Wheaton, or that you're going to go take a job that's on the Red Line. The odds are you're going to end up driving out on the roads. And every node I can think of in the County is built on a crossroads – one north/south road and one east/west road. And no matter how much you put in the center of the cup, it only leaves the cup in a road going this way or a road going that way. And it's all got to pour onto those other roads. And how we don't consider the impact on the links as you go up, I think is a mistake. And I don't know how we're going to – Phil asked the question, "What's it going to be like in twenty years?" You're twenty year projection shows things getting worse – and that's probably an optimistic projection. And I sort of feel like Phil and a little bit like Roger. People wanted things to get better. And this is not a prescription for things getting better. This is a prescription for things getting worse. And clever urban design in downtown Silver Spring and downtown Bethesda isn't going to change the fact that the experience for most people in most aspects of their lives is going to be worse, not better under the kind of conditions that flow from this scenario.

Royce Hanson,
If you want the easy way to make things better -- I won't say it's the easy way, but – is massive investments in infrastructure – massive investments in infrastructure.

Councilmember Elrich,
But what about things like taking curb lanes out for buses?

Royce Hanson,
Well, I've suggested that there may be many operational changes that could be made that would provide much better efficiency in the use of existing facilities. And I wrote a whole book on this once.

Councilmember Elrich,
It's not captured in here.

Council President Praisner,

The issue of investment in infrastructure is certainly, I thought, the thrust of your discussions about relating this to the Capital Budget. So we will continue to have that piece of the conversation – of the adequacy of that investment and this further conversation.

Royce Hanson,
That's correct.

Council President Praisner,
Last question, Marc.

Councilmember Elrich,
I was just going to say maybe it would be useful if you guys would put forward some of the tools – as unpleasant as some of them might be – to consider. Parking restrictions in downtown which limit the number of spaces are effective ways of limiting the number of cars without restricting development. You can still build, you know, 135 feet high and build very little parking – which means from a developer's perspective, you've all of a sudden got a lot more leasable space without putting any additional load on the roads. So why not discuss that? I'd like to see a discussion in here of what would happen – even some modeling – what would happen if curb lanes went out during rush hour so we could run Rapid Bus, which has a very little capital investment cost to us. I mean, the roads are sitting there; the lanes are sitting there. What would happen? I don't believe there are no solutions. But I also don't think that just simply saying, "Build anywhere, and hope that if things get bad enough people will ride a bus" – that's not a solution.

Council President Praisner,
The question I think you've been asked is to present additional suggestions for more aggressive solutions as it relates to the mobility issue.

Royce Hanson,
I think you will begin to see a good number of those as we undertake some of the new measures that you've asked us to do. For instance, the Zoning Code will have a substantial effect on that. Some of these things can be done within the Growth Policy; some of them take a lot more than Growth Policy. That's one of the reasons we've tried to indicate that this is one element.

Council President Praisner,
Well, we can relate those two, though, to the other work of the Planning Board; but it also is related to next steps. But the question is almost one of – and as we've presented this Growth Policy, we've always had a Growth Policy that additional work to be done – it was usually work to be done within the Growth Policy. Your suggesting the additional work to be done is related to the other work of the Planning Board or of others.

Royce Hanson,

A lot of it is.

Council President Praisner,

My question or my request to you is, We are in essence being asked to – and we will – take action on one piece on the faith that those other pieces will have the outcomes and will be coming in a timely fashion. My question is, “How do you more closely assure for the community that that faith is justified by the relationship of the other items?" So that might be something we could have a further conversation on. Thank you all very much. We’ll see you tonight at 8:00 p.m.